



Division of Health Sciences • 101 Cunningham Blvd • Booneville, Mississippi 38829
 Phone (662) 720-7236/(800) 555-2154 Fax (662) 720-7215

**ASSOCIATE DEGREE NURSING
 Medical Examination**

Full Name: _____
 (Last) (First) (Middle/Maiden)

Address: _____
 (Street, Apt #) (City) (State) (Zip Code)

Last 4 Digits of Social Security Number: _____ Date of Birth: _____

MEDICAL HISTORY (To be completed by the student): Do you presently have or have you ever had a history of any of the following? Please mark either yes or no for each section. Any 'yes' answers **MUST** be described in the comments section.

	YES	NO		YES	NO
1. Heart Disease			13. Lung Disease		
2. Kidney Disease			14. Musculo-Skeletal Disorders		
3. Cancer			15. Childhood Diseases		
4. Hypertension			16. Difficult Pregnancy		
5. Diabetes			17. Allergies		
6. Mental/Emotional Disorder			18. Other Diseases (list)		
7. Neurological Disorder			19. Hospitalizations		
8. Seizures (Epilepsy)			20. Serious Illness		
9. Cognitive Disorder			21. Liver Disorders		
10. Immune Disorder			22. Are you presently under the care of a physician? (explain)		
11. Blood Disorder			23. Lifestyle habits/practices (list) i.e., smoking, alcohol use, etc.		
12. Are you currently receiving any therapy/medication? (list)			24. Vision Problems / Hearing Problems / Speech Problems		

COMMENTS (identify by reference number): _____

I attest the information above is accurate to the best of my ability to determine. I understand that should my health status change on the above listed items (#1-24) while I am enrolled in the A.D.N. program, I am to report these changes to the Academic Head of the Division of Health Sciences and provide documentation as requested or deemed necessary.

 (Signature of Student)

 (Date)

Name of client: _____ Date of Physical Exam: _____

TO PHYSICIAN OR NURSE PRACTITIONER: Each item on the medical examination form must be completed in order to meet contractual guidelines of affiliating agencies and the nursing program. If you do not provide diagnostic services for any of the requested data, please refer the applicant to the appropriate agency. Thank you. Academic Head, Division of Health Sciences

PHYSICAL EXAMINATION (Must be completed by the Physician or Nurse Practitioner);

General State of Health _____
Vital Signs: Temp _____ Pulse _____ Resp _____ B/P _____
Nutritional Status _____
Mental Status _____
Skin _____
Head (and neurologic status) _____
Eyes, Ears, Nose, Throat (describe vision / hearing / teeth) _____
Lungs _____
Heart (rhythm, murmur, rub) _____
Breasts _____
Abdomen _____
Musculoskeletal _____
Genitourinary (please include menstrual history, bowel / bladder problems) _____

Statement of Eligibility (to be completed by the Physician / Nurse Practitioner)

As defined by the Southern Council on Collegiate Education for Nursing Task Force, Nursing is “a practice discipline with cognitive, sensory, affective, and psychomotor performance requirements.” The National Council of State Boards of Nursing has identified that a practicing nurse must have intellectual, interpersonal, and communication skills.

In addition, certain other abilities are necessary according to the National Council of State Boards of Nursing. These include: (1) emotional stability sufficient to assume responsibility / accountability for actions; (2) fine motor ability sufficient to perform skills such as picking up, grasping, and manipulating small objects with the hands; (3) physical mobility and strength sufficient to move about on a nursing unit and participate in client care (this involves lifting , standing, stooping, pushing); (4) physical stamina sufficient to perform client care for the length of a work shift; (5) auditory ability sufficient for assessment of client health; and (6) visual acuity sufficient to see objects, to read fine print, and to distinguish color.

Based on this history and physical assessment, it is my opinion that _____ should be able to meet the requirements identified above.

Based on this history and physical assessment, it is my opinion that _____ should be able to meet the requirements identified above with the exception of _____ with the following restriction _____ or recommendations _____.

(signature) (title) (date)

(address) (telephone)

