# Tennessee College of Applied Technology Elizabethton
# Medical History and Physical Examination
# Practical Nursing

**This report must be completed by a Physician, Physician's Assistant, or Nurse Practitioner and filed with the school registration requirements. However you, the applicant may complete the medical history section, then allow your healthcare provider to review the section when performing the physical examination. Physical examination must be within 3 months prior to date of admission.**

**NAME:** _____

**MEDICAL HISTORY**

1. Have you ever had any of the following? (Please check all that apply)

_____Skin Problems _____Diabetes _____Thyroid Disorder _____Asthma

_____Heart Trouble _____Kidney Disease _____Jaundice _____Hearing Problems

_____Rupture/Hernia _____Migraines _____Back Injury _____High Blood Pressure _____Cancer _____Hepatitis

_____Eye/Vision Problems _____Epilepsy/Seizure Disorder If you checked any of the above, please explain.

2. Do you have allergies? (List)_____

3. List any additional illnesses, surgeries, or injuries and give dates. _____

_____

_____

4. At present are you taking any medications or receiving any medical treatment? If so please list: _____

_____

(Please attach additional sheets if needed)

5. Have you had any treatment for drug or alcohol problems? _____ If so, please explain: _____

_____

6. Have you ever had any emotional problems? _____ If so, list treatment received: _____

_____

7. Are there any barriers that may affect your ability to care for and communicate with a patient? If so please explain: _____

_____

_____

8. Do you have any physical limitations that would prevent you from lifting up to 150 pounds, standing or bending? If so, please explain:

_____

_____

Applicant Signature_____ Date _____

(Rev. 11/2013)

# Physical Examination Form

*To be completed by a Physician, Physician's Assistant, or Nurse Practitioner*

NAME OF APPLICANT: _____

BLOOD PRESSURE: _____/_____ PULSE: _____

EYES: _____

(If glasses are needed, they should be obtained before entering the program.)

HEARING: _____

SKIN: _____

LUNGS: _____

HEART: _____

GI: _____

GU: _____

NEUROLOGICAL STATUS: _____

MUSCULOSKELETAL: _____

The applicant must be able to bend, stoop, lift, turn, can transfer a 150-pound patient as required by many health care employers. In your medical opinion, would this person be able to perform these duties?

YES_____ NO_____ COMMENTS:_____

Do you consider the applicant mentally and physically suited to undertake a position in nursing?

-----YES_____ NO_____ COMMENTS:_____

Based on your findings, are other tests indicated? _____ If so, please list these tests and their results.

_____

_____

By signing this physical examination form, I verify that:

-- This individual is mentally stable and able to safely administer prescribed medication, make prudent nursing judgments and take verbal orders accurately.

-- This individual can transfer a 150-pound patient as required by many health care employers.

COMMENTS:_____

_____

Healthcare Practitioner's Signature: _____ DATE: _____

Business Address: _____

Telephone: _____

**Required Lab Work:**
*Please enclose a copy of the results of a*

- ***Complete Blood Count (CBC) with your completed physical**. The CBC must be done within six months of admission to the program.*

- Drug Screen (this will be collected on an unannounced day *at the school*. This is the only drug screen accepted. These will be reviewed by a Medical Review Officer, and then sent directly to the school.)

(Rev.7/2012)

## Tennessee College of Applied Technology Elizabethton ~~ Immunization Record

**NAME:** _____

**To be completed by the appropriate health care personnel. All immunizations must be up to date according to regulations. Give date of most recent immunization.**

**For measles, mumps, and rubella the immunization record must reflect two measles vaccinations since 1979 or proof of immunity to measles unless born prior to 1957.**

**Measles (Rubella)**

**( ) Born Before 1957 or** Date: _____

**( ) Immunized with MMR twice, or** Date:_____

**( ) Positive titer (blood test that indicates immunity)** Date: _____

**Mumps**

**( ) Immunized with vaccine, or** Date: _____

**( ) Positive titer (blood test that indicates immunity)** Date: _____

**Rubella (Measles)**

**( ) Immunized with vaccine, or** Date: _____

**( ) Positive titer (blood test that indicates immunity)** Date: _____

**Varicella (Chicken Pox)**

**( ) History of the disease verified from a Healthcare practitioner** Date: _____

**( ) Proof of two doses of the Varicella Vaccine**

**( ) Positive titer (blood test that indicates immunity)** Date: _____

**Hepatitis B - Required**

**( ) Series of three immunizations completed, or**

**( ) Process of receiving vaccination** Date: _____

**Tetanus – *needed every 10 years*** Date: _____

**T. B. Skin Test or Chest X-Ray** Date: _____

**(*Required Annually)*** ***Date given / Date read and results***

**I certify that these immunizations are current and accurate.**
**Signature of Health Care Personnel _____Date_____**

***---------REQUIRED LAB WORK--------***

***Please enclose a copy of the results of the Complete Blood Count with your completed physical.***

1. **CBC**
2. **Drug Screen (this will be collected on an unannounced day *at the school*. This is the only drug screen accepted. These will be reviewed by a Medical Review Officer, and then sent directly to the school. )**

**(Rev. 7/2012)**