HEALTH EVALUATION FORM (Parts I & II)

PART I

Applicant, Please complete Part I, sign then give to health professional to review.

Name _____
(Last) (First) (Middle)

Mailing Address _____
(Number & Street) (City) (State/Zip Code)

Social Security # _____ Home Telephone # _____

Date of Birth _____ (Sex) Male _____ Female _____

Check if you ever had, or currently have, any of the following:

	Yes	No		Yes	No
Anxiety/Frequent Worry			Diabetes		
Depression/Extreme Fatigue			Bleeding Problems		
Heart Problems			Sinus Problems		
Kidney Disease			Tuberculosis		
High Blood Pressure			Hepatitis		
Stomach Disorders			Arthritis		
Seizures/Epilepsy			Asthma		
Fainting / Dizziness			Eye Problems		
Measles			Ear or Nose Problems		
Mumps			Cancer		
Rubella (German Measles)			Joint or Back problems		
Chicken Pox (Varicella)			Surgery		
Comments:					

1) Do you have any drug (medication) , food , or other allergies such as latex? _____ No _____Yes (If yes, please list)
Allergies:_____

2) Have you ever had a positive TB skin test? _____ No, or Yes_____: Date of First Reaction _____ mm____ (size)

3) Do you need any of the immunizations required for health professionals? (MMR x 2, Hep B x 3, Varicella x 2, Tdap and/or current TD) (Must have the vaccines listed or medical proof of the disease, i.e. antibody titer or timely medical diagnosis.)
No _____ Yes I need: _____

Family Medical History:
Check any of the following that apply:

	Y/N		Y/N		Y/N
Heart Disease		Kidney Disease		High Blood Pressure	
Diabetes		Cancer		Psychiatric/Emotional Disorders	
Other Chronic Illness (please list)					

Do you take any routine medications that may impair judgment, alertness, or motor function: _____ No _____Yes: Please list: _____
_____

Your Signature: _____ Date signed: _____

Continued on back (Part II)

PART II

TO THE EXAMINING HEALTH PROFESSIONAL:

The individual, who is identified in Part I, has been accepted for admission to the Associate Degree Nursing Program at Navarro College pending completion of all admission requirements. Please review the health history and other information provided by the individual in Part I of this form and complete part II below.

Height: _____ Weight: _____ Pulse (Rate and Rhythm): _____

Respirations: _____ Blood Pressure: _____

EYES: VISION: R_____ L_____ WITH CORRECTION: R_____ L _____

HEARING: R _____ L _____

NOSE: _____ SINUSES: _____

THROAT: _____ TONSILS: _____

LUNGS: _____ HEART: _____

ABDOMEN: _____ PALPABLE MASSES: _____

BACK: _____ CURVATURE OF SPINE: _____

EXTREMITIES:_____ GENERAL COMMENTS: _____

_____

Based on your evaluation, should this individual be able to perform the functional requirements of the Associate Degree Nursing Program and an RN? YES ____ NO _____ If no, please explain: _____

_____

Does this individual have routine medications that are likely to impair judgment, alertness, or motor skills?

No _____ Yes _____ If yes: please explain _____

_____

_____

	Address of Health Professional:
Signature of Health Professional	
Printed Name of Health Professional	
Date of Exam_____	Phone Number:

Revised: 4/10/00, 4/20/01, 4/17/02, 5/29/07, 5/2011, 5/2012