Gadsden Center for Health Education

SCHOOL OF PRACTICAL NURSING

At

GADSDEN TECHNICAL INSTITUTE

201 Martin Luther King Jr., Blvd. Quincy, Florida 32351* 850-875-8324(Main)* 850-875-7297(fax)*www.gadsdentech.org*

HEALTH RECORD
PHYSICAL EXAMINATION

NAME: _____ AGE: _____ DOB: _____ DATE: _____

MEDICAL HISTORY

TO BE COMPLETED BY APPLICANT

Please indicate if you have a history of the following health problems and the approximate dates or age when they occurred.

DISEASE	YES	DATE/ AGE	NO
Diphtheria			
Whooping Cough			
German Measles			
Chicken Pox			
Scarlet Fever			
Anemia			
Epilepsy			
Tetanus (Lockjaw)			
Rheumatic Fever			
Measles			
Mumps			
Smallpox			
Polio			
Sickle Cell Anemia			
Seizures			
Diabetes	***What Treatment?***		

Do you have any allergies (food, drugs, etc.)? _____ Yes _____No
If yes, name. _____

Any history of serious injuries? _____ Yes _____No
If yes, explain. _____

Any history of major surgery? _____ Yes _____No
If yes, explain. _____

List all medications you are currently taking and reason for taking each.

MEDICATION	REASON

PROGRAM ESSENTIAL TASKS

Health related occupations are demanding, both physically and emotionally. Before entering a program in the health field, it is important to review the following tasks which have been established. Their performance is essential for success in the program.

Mental and Emotional Requirements:

YES	NO	
☐	☐	Ability to cope with a high level of stress
☐	☐	Ability to make fast decisions under high pressure
☐	☐	Ability to cope with the anger/fear/hostility of others in a calm manner
☐	☐	Ability to interpret audible sounds of distress
☐	☐	Ability to manage altercations
☐	☐	Ability to concentrate
☐	☐	Ability to cope with confrontation
☐	☐	Ability to handle multiple priorities in a stressful situation
☐	☐	Ability to assist with problem resolution
☐	☐	Ability to work alone
☐	☐	Ability to demonstrate a high degree of patience
☐	☐	Ability to adapt to shift work
☐	☐	Ability to work in areas that are close and crowded

Please explain any other significant health issues: _____
_____

I certify by my signature that the above information is true, complete and accurate.

_____ _____

APPLICANT SIGNATURE **DATE**

Original to be retained with Gadsden Center for Health Education, Nursing Department, at Gadsden Technical Institute.

Mission Statement

The mission of Gadsden Technical Institute is to recognize the worth and potential of each student. We are committed to providing opportunities for basic and advanced instruction in a conducive learning environment. The Center encourages academic and technical curiosity, innovation and creativity by integrating applied academic skills in all occupational areas. We strive to instill the attitudes and skills necessary to produce motivated, self-sufficient individuals who are able to function effectively in our ever-changing, complex society.

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HEALTH RECORD

TO BE COMPLETED BY HEALTH CARE PROVIDER

NAME: _____ DATE: _____

(Documentation of the following information is required).

MEDICAL HISTORY VERIFICATION

IMMUNIZATIONS/BOOSTER	DATE(S) RECEIVED	COMMENTS/FOLLOW-UP (if applicable)
Tetanus		
MMR (Measles, Mumps, Rubella) Vaccine X2		
Hepatitis B Vaccine Series (3)		
Varivax X2 or Varicella *(Titer)*		
Flu Vaccine		
OTHER		
TB (Tuberculosis Test. Blood Test Preferred)		**Results:**
Chest X-ray (if previous positive TB test)		

*****Immunization/shot record must be submitted with this physical examination**

PHYSICAL EXAMINATION

		Normal	Abnormal	COMMENTS (for Abnormal)
1.	**EYES:** (Discharge, Strabismus, Pterygium, etc.)	☐	☐	
2.	**EARS:** (Discharge, Evidence of deafness, middle ear or mastoid disease, drums absent, perforated, dull, retracted.)	☐	☐	
3.	**NOSE:** (Obstruction, evidence of chronic sinus infection)	☐	☐	
4.	**THROAT**: (Tonsils enlarged or removed)	☐	☐	
5.	**MOUTH:** (Missing teeth, pyorrhea, caries, abnormal tongue or palate)	☐	☐	
6.	**NECK**: (Thyroid enlargement)	☐	☐	
7.	**BREAST:** (Abnormal discharges, nodules, masses)	☐	☐	
8.	**LUNGS:** (Conformation, respiratory movement, breathing sounds)	☐	☐	
9.	**ARTERIES:** (Peripheral pulsation)	☐	☐	
10.	**HEART:** (Enlargement, thrills, murmurs, rhythm)	☐	☐	
11.	**VEINS:** (Varicose, location, severity)	☐	☐	
12.	**ABDOMEN:** (Scars, masses, palpable liver or spleen, tenderness)	☐	☐	
13.	**HERNIA:** (Type, severity)	☐	☐	
14.	**GENETALIA/MALE:** (Discharge, varicocele, prostate)	☐	☐	

		Normal	Abnormal	COMMENTS (for Abnormal)
15.	**GYNECOLOGICAL:** (Significant abnormal condition, severity)	☐	☐	
16.	**ANO-RECTAL:** (Hemorrhoids, prolapse, fissure, fistula)	☐	☐	
17.	**NERVOUS SYSTEM:** (Gait, reflexes, sensation, seizure)	☐	☐	
18.	**PSYCHIATRIC:** (Mood, abnormal behavior, etc.)	☐	☐	
19.	**SKIN:** (Lesions, scars, abnormalities, extent and severity)	☐	☐	
20.	**MUSCULOSKELETAL:** (Congenital or acquired impairment, etc.)	☐	☐	
21.	**GOOD HEALTH HABITS**	☐	☐	
22.		**(Other)**		
23.		**(Other)**		

PROGRAM ESSENTIAL TASKS

Health related occupations are demanding, both physically and emotionally. Before entering a program in the health field, it is important to review the following tasks which have been established. Their performance is essential for success in the program.

To be completed and signed by the Health Care Provider ONLY:
Physical Requirements:

- ☐ Ability to perform repetitive tasks
- ☐ Ability to walk the equivalent of five miles per day
- ☐ Ability to reach above shoulder level
- ☐ Ability to project audible verbal communications at a distance of 4 feet
- ☐ Ability to demonstrate high degree of manual dexterity
- ☐ Ability to work with chemicals and detergents
- ☐ Ability to tolerate exposure to dust and/or odors
- ☐ Ability to grip
- ☐ Ability to distinguish colors
- ☐ Ability to lift a minimum of 25 lbs. & maximum of 100 lbs.
- ☐ Ability to bend knees
- ☐ Ability to sit or stand for long periods of time
- ☐ Ability to perform CPR
- ☐ Vision within normal limits
- ☐ Hearing with normal limits

ADDITIONAL COMMENTS: _____

_____

I have completed the physical examination, reviewed the health record and find this person to be free of communicable disease, meet the above requirements and is able to participate in the program selected above.

Office Stamp (if applicable**)**

_____ _____

Signature and Title of Examiner **Date**

It is my recommendation that this person **not participate** in the Program at this time.

_____ _____

Signature and Title of Examiner **Date**

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