COLORADO CHRISTIAN UNIVERSITY
School *of* Nursing and Health Professions

STUDENT PHYSICAL EXAM FORM

DIRECTIONS: This form is composed in three parts. Parts I and II are to be completed by the Applicant's Healthcare Provider while Part III should be completed by the Student Applicant.

Part I-

After the Healthcare Provider has completed Part I, applicants must return Part I to Vickie Holocher, Student Services Advisor at vholocher@ccu.edu or 720-872-5712 (fax). Part I must be submitted before the interview for admission.

Part II-

After the Healthcare Provider has completed Part II, this section should be submitted to our document tracking system, myClinicalExchange, upon acceptance into the Nursing Program.

Part III-

After the Applicant has completed Part III, this section should be submitted to our document tracking system, myClinicalExchange, upon acceptance into the Nursing Program.

Please note: Further instructions on how to submit documents into myClinicalExchange will be provided upon acceptance into the Nursing Program.

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Part I – To be completed by a Healthcare Provider (*Physician, NP or PA)*
Fit for Practice Form

_____ _____
Student Last Name First Name MI Date of Birth

_____
Street Address City State

Signed Statement of "FIT FOR PRACTICE"

As a Healthcare Provider, I have completed the examination required for the above named student who is applying for nursing school.

My signature below verifies that _____ (*student name*) is fit physically, emotionally stable, and mentally competent to complete the clinical requirements for the role of the nursing student in the clinical setting. This includes but is not limited to:

- The ability to regularly work in a non-latex free environment
- The ability to lift and move an estimated weight equal to 50 pounds (Greater than 50 pounds done with assistance or lifts)
- The ability to see (At least 20/40 in each eye with or without correction and at least 70 degrees peripheral in horizontal meridian measured in each eye)
- The ability to hear (Must perceive forced whispered voice ≥ 5 ft. with or without hearing aid)
    - If unable to hear forced whispered voice from 5 ft then must be assessed by audiologist to determine that average hearing loss in better ear is ≤ 40 dB. If this level is achieved audiologist to sign below.
    - Printed name and Signature of audiologist:
      _____
- The ability to stand, sit, bend, kneel, crouch, squat, walk, operate equipment and adapt to violent patient situations
- The ability to perform all of these items frequently during an 8 – 12 hour clinical work day

Please select one of the following:

_____ ***Fit for Practice meeting all requirements***

_____***Fit for Practice with the following Restrictions (please specify): _____***

_____

_____***Does NOT meet the requirements for "Fit for Practice" without likelihood of injury to the student.***

Healthcare Provider Information:

_____
Name

_____
Street Address City State

Signature of Healthcare Provider: _____

Credentials: _____ Date: _____

Please return this form immediately to:

Vickie Holocher- Student Services Advisor

vholocher@ccu.edu

720-872-5712 (fax)

Information contained in this form will remain confidential and will not be disclosed without the written permission of the student, in compliance with The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule.

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Part II – To be completed by a Healthcare Provider (*Physician, NP or PA*)

Student Name_____ Birth date_____

Height_____ Weight_____ Pulse_____

Blood Pressure_____ Resp_____

Vision (Snellen) / R/L Corrected / R/L

Near Vision_____ Color Blindness _____

Hearing_____R_____L

Check if Abnormal:	Comments:
___General Appearance	_____
___Head & Scalp	_____
___Face & Skin	_____
___E.E.N.T.	_____
___Neck	_____
___Heart	_____
___Lungs	_____
___Breasts	_____
___Abdomen	_____
___Back & Spine	_____
___Extremities	_____
___Lymphatic	_____
___Neurological	_____
___Genitourinary	_____

Additional Comments:

_____

_____

Healthcare Provider (*Physician, NP or PA*)

Name_____

Address_____

Signature _____ **Date** _____

Upon admittance into the Nursing Program please return this form to:

myClinicalExchange
https://www.myclinicalexchange.com/Default.aspx

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Part III – To be completed by the <u>student</u> applicant prior to the physical exam.

NAME: _____

TELEPHONE: _____ MOBILE PHONE: _____

ADDRESS: _____

STREET CITY STATE ZIP

Injuries:

Hospitalization:

Other: (Check if condition applies to you)		Comments
Anemia	_____	_____
Arthritis	_____	_____
Asthma	_____	_____
Back or neck Injuries	_____	_____
Bladder/Bowel	_____	_____
Cancer	_____	_____
Diabetes	_____	_____
Hearing Problems	_____	_____
Heart Disease	_____	_____
High B/P	_____	_____
Cognitive Disorder	_____	_____
Head Concussion	_____	_____
Seizures	_____	_____
Thyroid Disease	_____	_____
Ulcer	_____	_____
Visual Problems	_____	_____

MEDICATIONS YOU ARE PRESENTLY TAKING:

_____

ALLERGIES: Food _____ Drug _____ Latex _____ Other (please specify _____

PRESENT OR CHRONIC MEDICAL PROBLEMS: _____

_____

_____

I hereby affirm that the information provided on this form is correct.

Student Signature_____ **Date** _____

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