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.
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

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.

Dev. 04/20/10; Rev 8/14/2013
Part II – To be completed by a Healthcare Provider *(Physician, NP or PA)*

Student Name__________________________  Birth date________________________

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Pulse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Blood Pressure</th>
<th>Resp</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vision (Snellen)</th>
<th>R/L</th>
<th>Corrected</th>
<th>R/L</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Near Vision</th>
<th>Color Blindness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hearing</th>
<th>R</th>
<th>L</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Check if Abnormal:**

- [ ] General Appearance
- [ ] Head & Scalp
- [ ] Face & Skin
- [ ] E.E.N.T.
- [ ] Neck
- [ ] Heart
- [ ] Lungs
- [ ] Breasts
- [ ] Abdomen
- [ ] Back & Spine
- [ ] Extremities
- [ ] Lymphatic
- [ ] Neurological
- [ ] Genitourinary

Comments:

Additional Comments:

____________________________________________________

Healthcare Provider *(Physician, NP or PA)*

Name__________________________________________________________________________

Address___________________________________________________________

Signature _____________________________________________ Date _________________

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

myClinicalExchange


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.
Part III – To be completed by the student 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 __________

Upon acceptance to the Nursing Program please return this form to:
myClinicalExchange

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