AMI, COLLEGE OF NURSING

HEALTH EVALUATION FORM (Parts I & II)

Applicant: Complete Part I, Sign your name at the bottom of this page.

Show health professional, Part I, Documented immunizations, and/or tests you have had.

Part II is to be completed by a health professional (i.e., physician, nurse practitioner, etc.).

PART I

Printed Name _____
(Last) (First) (Full Middle Name)

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

Social Security #_____ Cell Ph.#_____ Home Ph.#_____

Date of Birth_____ (Sex) Male_____ Female ____

HEALTH PROFESSIONAL: Please review Health History

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

	Yes	No		Yes	No
Anxiety			Impaired hearing		
Depression			Impaired sense of smell		
Diabetes			Impaired sense of touch		
Seizures/Epilepsy			Impaired vision		
Fainting / Dizziness			Lifting restriction		
ADHD			Other physical limitation(s):		
Other:					
Comments:					

1) Do you have any medication, food, latex, or other allergies?____No ____Yes If yes, please list allergies:_____

_____

2) Ever had a positive TB skin test? No____If Yes__ complete the following: Attach copy of the first positive reaction documentation and a copy of the last Negative Chest X-Ray report.

Health care provider immunizations are required: MMR x 2, Hep B x 3, Varicella x 2**, Tdap** (**must have history of one Tdap,** then TD/Tdap boosters must not expire prior to your graduation date).
TB skin test must not expire before May of your first year. Influenza vaccine **for traditional students** will be required when you are directed to do so in the Fall **but** if you are a Bridge applicant, it should be up to date for clinical in June.

Do you take any routine medications that may impair judgment, alertness, or motor function?
No___ Yes___ If yes, please list: _____

Applicant Signature:_____ Date Signed: _____

Physical Assessment Form: Continued next page (Part II)

AMI, COLLEGE OF NURSING

APPLICANT NAME:_____ PART II Submit pages 1 & 2 before Orientation

TO THE EXAMINING HEALTH PROFESSIONAL: The individual, identified in Part I, has applied for admission to a Nursing Program at AMI College of Nursing. Please review the previous page (Part I) which has the student's health history and other information provided by the student. Complete Part II below.

Height:____Weight:_____Pulse + Rate/Rhythm:_____Resp.____Blood Pressure_____

Vision (with correction if applicable): R_____ L_____ Correction necessary? ____

Hearing (with aid if applicable): R_____ L_____ Aid necessary? _____

Sense of smell:_____ Sense of touch: _____

Other: _____

Any assisting patient restrictions, or lifting restrictions, _____

_____

_____

Based on your evaluation, should this individual be able to perform the functional requirements of the AMI College of Nursing Program Student Nurse, i.e., assisting/positioning patients, lifting, assessing: seeing, hearing, sense of smell, and sense of touch

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 - _____

_____

Attach signed documentation for any immunizations given.

Health Professional

Signature:	Address:
Printed Name:	
Date of Exam:	Phone Number: