CYBERTEX
Institute of Technology

Vocational Nursing - Admission Medical Clearance and Physical Examination

Student Name _____ **DOB** _____ **Sex:** □ **M** □ **F**

Address _____ **Telephone** _____

History: (All serious medical and psychiatric disease, Diabetes, epilepsy, HTN, ASCH, arrhythmias) _____

_____

□ Diabetes □ ASHD □ CA □ Psychiatric issues □ CHF

Major surgeries: _____

_____

_____

_____

_____

Family History: □ Diabetes □ ASHD □ CA □ Psychiatric □ CHF □ Other _____

Yes □ No □ Demonstrates good body mechanics; Can lift/carry a minimum of twenty-five (25) lbs. independently and fifty (50) lbs. with assistance; Demonstrates bending at the knees.

Yes □ No □ Has normal/corrected vision and hearing to normal range (=with corrective lens = without corrective lens)

Yes □ No □ Exhibits ability to tolerate intermittent sitting, standing, stooping, and walking; Full range of motion.

Yes □ No □ Exhibits full dexterity for all extremities.

Yes □ No □ Exhibits ability to differentiate odors and colors in the clinical setting.

Yes □ No □ Exhibits ability to stand on carpeting, linoleum, or be seated at a standard desk at the nurse's station using an office chair for a varying amount of time.

Yes □ No □ Demonstrates emotional stability and maturity in various circumstances through interpersonal relationships with staff, patients and visitors. Information obtained via a brief interview.

PHYSICAL (WNL= within normal limits)

1. General appearance _____ □WNL
2. Eyes _____ □WNL
3. Ears, Nose, & Throat _____ □WNL
4. Teeth and Gums _____ □WNL
5. Thyroid _____ □WNL
6. Heart _____
7. Blood Pressure _____ Pulse _____
8. Lungs _____ □ WNL
9. Abdomen _____ □ WNL
10. Nervous System _____ □ WNL
11. Extremities _____ □WNL
12. Other _____ □WNL
13. Edema _____ □ None observed

TB Skin Test

Date given: _____ Date Read: _____ □ Positive □ Negative

Type of test: _____ by Whom: _____

Millimeters of Indurations: _____

Date X-ray Taken _____ Results _____

_____ No further follow-up necessary unless signs/symptoms of tuberculosis develop

CERTIFICATION OF PHYSICAL EXAMINATION

This is to certify that I have examined _____ and find him/her free of communicable diseases and any physical or mental disabilities that might interfere with performing his/her duties, except as follows:

_____

_____

Date of Examination _____ Signature (Physician/PA/APRN) _____

_____ agrees to release this information to CyberTex Institute of Technology and designated clinical site facility.

(Student please sign)