**LEX LA-RAY TECHNICAL CENTER**

**PRACTICAL NURSING PROGRAM**

ADMISSION PHYSICAL EXAMINATION

To be completed upon admission into the program

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

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle Maiden

PHYSICAL EXAMINATION

Height\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_ Temp\_\_\_\_\_\_\_\_\_ Pulse\_\_\_\_\_\_\_\_ Respirations\_\_\_\_\_\_\_\_\_\_ BP\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Normal** | **Abnormal** | **Comments** |
| **General Appearance** |  |  |  |
| **Head and Scalp** |  |  |  |
| **E.E.N.T** |  |  |  |
| **Mouth** |  |  |  |
| **Skin** |  |  |  |
| **Chest, breasts, lungs** |  |  |  |
| **Heart and Vascular System** |  |  |  |
| **Lungs** |  |  |  |
| **Abdomen** |  |  |  |
| **Extremities** |  |  |  |
| **Spine and Musculoskeletal** |  |  |  |
| **Neurological** |  |  |  |

Is this student currently under a physician’s care or taking medications? \_\_\_\_Yes \_\_\_\_No

Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(cont. on back)**

**IMMUNIZATIONS: Attach all documentation including immunization record and laboratory results (if required).**

**TB Test (2-step)**  1.) Date: \_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_ 2. ) Date: \_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_

*Must be after June 16, 2023*

If positive, chest X-Ray is required. Date:\_\_\_\_\_\_\_\_\_\_ Result:\_\_\_\_\_\_\_\_\_\_

**Varicella** Titer value:\_\_\_\_\_\_\_\_ Does this constitute immunity? \_\_\_\_Yes \_\_\_\_No

**Measles**  Titer value:\_\_\_\_\_\_\_\_ Does this constitute immunity? \_\_\_\_Yes \_\_\_\_No

**Mumps**  Titer value:\_\_\_\_\_\_\_\_ Does this constitute immunity? \_\_\_\_Yes \_\_\_\_No

**Rubella**  Titer value:\_\_\_\_\_\_\_\_ Does this constitute immunity? \_\_\_\_Yes \_\_\_\_No

**Hepatitis B** Dates of injection 1.\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_ 3.\_\_\_\_\_\_\_\_\_\_ Titer value: \_\_\_\_\_\_\_\_\_\_\_\_

**Tdap booster** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_(must be within last 10 years)

**Is this individual in suitable physical and emotional health for practical nursing training?** \_\_\_\_Yes \_\_\_\_No

Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Healthcare Provider’s Signature**

**Provider’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please print**

**Provider’s address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**