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:_____

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

TB Test (2-step) 1.) Date: _____ Result: _____ 2.) Date: _____ Result: _____
Must be <u>after</u> June 16, 2022
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:_____