



Bachelor of Science in Nursing

NURSING APPLICANT MEDICAL EVALUATION

Note: All information requested on this form must be provided before it is returned.

Legal Name _____ Social Security Number _____
 Date of Birth _____ Age _____ Bethel I.D.# (if known) _____ Female Male
 Address _____

APPLICANT HISTORY	EXAMINATION																																																																																																																																															
Please complete prior to physician's exam.	To be completed by physician (within one year).																																																																																																																																															
<p>1. Indicate whether you have had the following:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">YES</th> <th style="width: 10%; text-align: center;">NO</th> </tr> </thead> <tbody> <tr><td>Abnormal bleeding/bruising</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Anemia</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Asthma</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Back problems</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Blood disease</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Broken bones/stress fractures</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Cancer</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Diabetes</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Emotional problems</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Hearing impairment</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Heart murmur/problems</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Hepatitis/jaundice</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>High blood pressure</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Loss of eyesight</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Neuromuscular disorder</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Rheumatic fever</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Scoliosis</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Seizures</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Single organs (kidney, eye, testicle, etc.)</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Tuberculosis</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Other chronic conditions</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> </tbody> </table> <p>2. Have you been ill in the last month? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. Do you take any prescription medication? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>4. Give details for any of the following:</p> <table style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td>Have you ever been hospitalized?</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Have you ever had surgery?</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Have you ever had a serious accident/injury?</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> </tbody> </table> <p>If yes, explain: _____</p> <p>5. Have you had an eating disorder? (past or present) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6. Are there any conditions you'd like to discuss? (nutrition, weight training, tobacco, pregnancy, birth control, AIDS, alcohol, steroids, other) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>7. Have you ever had a positive reaction to the Mantoux (TB) test? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>8. Do you have any medication allergies? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please list: _____</p> <p>I do not know of any existing physical conditions or additional health reasons that would preclude my entrance into the graduate nursing program. I certify that the answers to the above questions are true and accurate.</p> <p>Signature _____ Date _____</p> <p style="text-align: center;">(Please read and sign Confidentiality Agreement on reverse side.)</p>		YES	NO	Abnormal bleeding/bruising	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Back problems	<input type="checkbox"/>	<input type="checkbox"/>	Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones/stress fractures	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Emotional problems	<input type="checkbox"/>	<input type="checkbox"/>	Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur/problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/jaundice	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Loss of eyesight	<input type="checkbox"/>	<input type="checkbox"/>	Neuromuscular disorder	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Single organs (kidney, eye, testicle, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Other chronic conditions	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious accident/injury?	<input type="checkbox"/>	<input type="checkbox"/>	<p>HT _____ WT _____ BP _____</p> <p>Vision _____ R _____ L _____</p> <p>Glasses: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Contact Lenses: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;"></th> <th style="width: 15%; text-align: center;">Normal</th> <th style="width: 15%; text-align: center;">Abnormal</th> <th style="width: 30%; text-align: center;">Comments</th> </tr> </thead> <tbody> <tr><td colspan="4">HEENT</td></tr> <tr><td>Fundoscopic</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> <tr><td>Ears</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> <tr><td>Mouth</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> <tr><td>Throat</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> <tr><td>Dental</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> <tr><td>Thyroid</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> <tr><td>Nodes</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> <tr><td>Lungs</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> <tr><td>Cardiac</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> <tr><td>Abdomen</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> <tr><td>Genitalia (optional)</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> <tr><td>Hernia</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> <tr><td>Skin</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> <tr><td>Neuro</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> <tr><td>Musculoskeletal</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td>_____</td></tr> </tbody> </table> <p>I herewith certify that _____ has been evaluated and found to have no contraindications for nursing practice.</p> <p>Due to (if not cleared) _____ _____ _____</p> <p>Modifications or exceptions _____ _____ _____ _____</p> <p>How long have you been the patient's physician? _____</p> <div style="border: 1px solid black; padding: 5px; text-align: center;"> <p>PHYSICIAN: Please complete and sign other side of this form.</p> </div>		Normal	Abnormal	Comments	HEENT				Fundoscopic	<input type="checkbox"/>	<input type="checkbox"/>	_____	Ears	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____	Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____	Dental	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____	Nodes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	_____	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____	Genitalia (optional)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neuro	<input type="checkbox"/>	<input type="checkbox"/>	_____	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
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(over, please)

Confidentiality Agreement

Bethel College takes care to maintain strict confidentiality of your records and health information. However, in order for us to assure your safety in the clinical setting and meet the contract requirements of our clinical agencies, the Nursing Department must keep certain information on file. It must also provide the affiliating clinical agencies with requested information from your file. This includes information such as immunization status and history of any medical condition that may need to be monitored. It is because of our strong regard for confidentiality that we want you to be aware of this prior to your physical. Our aim is to help you safely participate in the nursing program at Bethel College.

"I have read and understand the above statement. I agree that Bethel may release medical information about me for clinical purposes."

Signature (Applicant) _____ Date _____

Physician-Documented Immunization Record

Diphtheria (within past 10 years) _____
Month/Year

Tetanus (within past 10 years) _____
Month/Year

Rubeola (Red Measles—not required if born before 1957)

Must have **two** doses of live vaccine after first birthday _____
Month/Year (first dose) Month/Year (second dose)

or laboratory evidence of immunity (titer) _____
Month/Year of Titer Results

Rubella (German Measles—not required if born before 1957)

Must have one dose of live vaccine after first birthday _____
Month/Year

or laboratory evidence of immunity (titer) _____
Month/Year of Titer Results

Mumps (not required if born before 1957)

Must have one dose of live vaccine after first birthday _____
Month/Year

or history of the illness _____
Month/Year of Illness

Chicken Pox

History of the illness _____
Month/Year of Illness

or must have two doses of varicella vaccine _____
Month/Year (first dose) Month/Year (second dose)

or laboratory evidence of immunity (titer) _____
Titer date and results

Hepatitis B

Must have three doses _____
Month/Year (first dose) Month/Year (second dose) Month/Year (third dose)

Or sign Hepatitis B Waiver below:

I understand that due to required learning experiences as part of the PACE nursing major I may be exposed to blood or other potentially infectious materials and may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been notified that Hepatitis B vaccination is a recommended immunization for the nursing major. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

Signature (applicant) _____ Date _____

Signature (physician) _____ Date _____

Name (please print) _____

Clinic Name _____ Phone (_____) _____

Address _____

Note: All information requested on this form must be provided before it is returned.