

**NURSING APPLICANT MEDICAL EVALUATION**  
**Bethel University Health Services**  
**3900 Bethel Drive, St. Paul, MN 55112**

Student name \_\_\_\_\_

Social Security Number \_\_\_\_\_

Address \_\_\_\_\_

Bethel I.D. # (if known) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Male  Female

**APPLICANT**  
**Please Complete Prior To Physician's Exam**

**EXAMINATION**  
**To Be Completed By Physician (within 6 months)**

**HISTORY**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1. Indicate the following you have had:     | <b>YES</b>               | <b>NO</b>                |
| 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 eye sight                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Neuro muscular 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"/> |

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | <b>YES</b>               | <b>NO</b>                |
| 2. Have you been ill in the last month?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you take any prescription medication?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. <b><u>Give details for any of the following:</u></b>  |                          |                          |
| 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"/> |
| 5. Have you had an eating disorder?<br>(past or present)   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are there any conditions you would like<br>to discuss? (Nutrition, weight training,<br>tobacco, pregnancy, birth control, AIDS,<br>alcohol, steroids, seat belts, other). | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had a positive reaction to<br>the mantoux (TB) test?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have any medication allergies?<br>If yes, please list: _____   | <input type="checkbox"/> | <input type="checkbox"/> |

I do not know of any existing physical conditions or additional health reasons that would preclude my entrance into the nursing program. I certify that the answers to the above questions are true and accurate.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

HT _____	WT _____	BP _____	Glasses: <input type="checkbox"/>	<b>YES</b>	<b>NO</b>
Vision _____	R _____	L _____	Contact Lenses: <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Normal	Abnormal	Comments
<b>HEENT</b>			
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 (opt'l)	<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"/>	_____

I herewith certify that \_\_\_\_\_ has been evaluated and found to have no contraindications for nursing practice.

Due to (if not cleared) \_\_\_\_\_

Modifications or exceptions \_\_\_\_\_

How long have you been patient's physician? \_\_\_\_\_

**PHYSICIAN: PLEASE COMPLETE AND SIGN BACK PAGE OF THIS FORM.**

*(over please)*

## PHYSICIAN DOCUMENTED IMMUNIZATION RECORD

**Diphtheria** (within past ten years): \_\_\_\_\_ **Tetanus** (within past ten years): \_\_\_\_\_  
(month/year) (month/year)

**Rubeola (Red Measles)** - not required if born before 1957:

Must have two doses of live vaccine - one after first birthday and the second after 12th birthday:

\_\_\_\_\_  
1st dose (month/year) \_\_\_\_\_  
2nd dose (month/year)

**-OR-**

Laboratory evidence of immunity (titer): \_\_\_\_\_  
titer date and 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): \_\_\_\_\_  
titer date and 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: \_\_\_\_\_  
(date of illness)

**Chickenpox:**

History of the illness \_\_\_\_\_  
(month/year)

**-OR-**

Must have two doses of varicella vaccine \_\_\_\_\_  
(month/year) (month/year)

**-OR-**

Laboratory evidence of immunity (titer): \_\_\_\_\_  
titer date and results

**Hepatitis B :** Must have three doses **OR** Sign Waiver below

\_\_\_\_\_  
#1(month/year) #2(month/year) #3(month/year)

**Hepatitis B Waiver:**

I understand that due to required learning experiences as part of the 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.

\_\_\_\_\_  
Applicant's Signature Date

**Physician's Signature (MD or DO)** \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_

Clinic \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

**STATEMENT REGARDING NURSING PROGRAM  
PHYSICALS**

As a prospective nursing student at Bethel University, you will be required to have a complete physical exam by a physician of your choice before you participate in any clinical activities. You are also required to give the college documentation of your immunization status.

The staff of Bethel University Health Services works hard 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. They 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 to safely participate in the Bethel University Nursing Program.

**I HAVE READ AND UNDERSTAND THE ABOVE  
STATEMENT AND AGREE THAT BETHEL MAY  
RELEASE MEDICAL INFORMATION ABOUT ME FOR  
CLINICAL PURPOSES.**

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Applicant Signature

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Date