Institute for Accelerated RN Success, Inc. **Student Health Physical Form**

Personal Information (PLEASE PRINT) *ALL ITEMS IN BOLD PRINT MUST BE COMPLETED!!

Name ____ **Sex** {circle} **M F**
FIRST **MIDDLE** **LAST**

Date of Birth {Month/Day/Year} ______/_____/_____ **Social Security Number of Student** _________ - ________ - ________

Mailing Address ___________________________________ **City** ____________________________ **Zip Code** __________

Place of Employment ______________________ **Home Phone** _____________________ **Work Phone** ___________________

Person to Notify in an Emergency ____________________ **Phone** _____________________ **Alternate** _____________________

Family Doctor ___________________________________ **Phone** _____________________ **Alternate** _____________________

Is this student covered by private health care/medical insurance and/or Medicaid? ____ Yes ____ No _____

Name of private healthcare/medical insurance provider: ____

Policy Holder's Name: ____________________________________ **Social Security # :** _________ - _________ - _________

Group Name: _______________________________ **Group #:** ______________ **Policy #:** ________________________________

Medical History **(Answer ALL questions by checking the YES or NO boxes. Explain ALL "Yes" answers in the space below!!)**

	GENERAL MEDICAL HISTORY:	YES	NO
1.	HAVE YOU HAD ANY MEDICAL PROBLEM OR PHYSICAL INJURY SINCE YOUR LAST PHYSICAL EXAM?	ڨ	ڨ
2.	Do you have asthma?..	ڨ	ڨ
3.	Do you have diabetes?	ڨ	ڨ
4.	Do you have high blood pressure?	ڨ	ڨ
5.	Do you have seizures?..	ڨ	ڨ
6.	Do you have sickle cell trait?	ڨ	ڨ
7.	Have you have any other major medical problem?	ڨ	ڨ
8.	Have you ever been hospitalized or had surgery?	ڨ	ڨ
9.	Do you cough, wheeze, or have trouble breathing when exercising?	ڨ	ڨ
10.	Do you use an inhaler?	ڨ	ڨ
11.	Do you have a single organ (testicle or kidney)?	ڨ	ڨ
12.	Are you currently taking any medicines or do you take any medicines on a regular basis (prescription or over-the-counter)?	ڨ	ڨ
13.	Have you ever taken any supplements or vitamins to help with weight loss, weight gain, or to improve performance?	ڨ	ڨ
14.	Do you have any allergies (seasonal, insects, food, or medicines)?	ڨ	ڨ
15.	Have you ever had a rash or hives develop during or after exercise?	ڨ	ڨ
16.	Do you have any skin problems other than acne?	ڨ	ڨ
17.	Have you ever had a head injury, been knocked out, lost your memory, had your "bell rung", or a concussion?	ڨ	ڨ
18.	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	ڨ	ڨ
19.	Have you ever had a "stinger", "burner", or pinched nerve? ...	ڨ	ڨ
20.	Have you ever become ill from exercising in the heat?	ڨ	ڨ
21.	Have you had mononucleosis or any significant illness in the last 60 days?	ڨ	ڨ
22.	Do you have trouble with your eyes/vision/wear glasses or contacts?	ڨ	ڨ
23.	Do you have trouble with your hearing/wear hearing aids?	ڨ	ڨ
24.	Do you want to weigh more or less than you do now?	ڨ	ڨ
25.	Do you lose weight regularly to meet weight requirements for your sport or other reasons?	ڨ	ڨ
26.	Do you feel stressed out, overly tired, or depressed?	ڨ	ڨ
27.	Are there any other issues you would like to discuss with the doctor?..	ڨ	ڨ

	FEMALES ONLY:	YES	NO
28.	Are your periods regular (every month)?....................................	ڨ	ڨ
29.	Are your periods heavy?..	ڨ	ڨ
30.	When was your first period? Month ________ Year ________		
31.	When was your last period? Month ________ Year ________		
	CARDIAC HISTORY:	YES	NO
1.	Have you ever passed out during or after exercise?	ڨ	ڨ
2.	Have you ever been dizzy during or after exercise?	ڨ	ڨ
3.	Have you ever had chest pain or chest pressure during or after exercise?	ڨ	ڨ
4.	Do you tire easily or more quickly than your friends during exercise?	ڨ	ڨ
5.	Have you ever had racing of your heart or skipped heartbeats?	ڨ	ڨ
6.	Have you ever been told you had a heart murmur?	ڨ	ڨ
7.	Have you ever been told you had an enlarged heart?	ڨ	ڨ
8.	Has any member of your family:		
	- died of heart problems or sudden death before age 50?..........	ڨ	ڨ
	- been told they had a serious heart problem before age 50?....	ڨ	ڨ
	- been told they had Marfan's Syndrome?..................................	ڨ	ڨ
9.	Has a physician ever denied or restricted your participation in sports?...	ڨ	ڨ
	ORTHOPAEDIC HISTORY:		
1.	Have you ever broken or fra ctured any bones?..........................	ڨ	ڨ
2.	Have you ever dislocated or partially dislocated any joint?.......	ڨ	ڨ
3.	Have you had any problems related to your:		
	- neck, spine, or back?..	ڨ	ڨ
	- shoulders?..	ڨ	ڨ
	- elbows?..	ڨ	ڨ
	-wrists, hands, or fingers?...	ڨ	ڨ
	- hips?...	ڨ	ڨ
	- knees?...	ڨ	ڨ
	- ankles, feet, or toes?..	ڨ	ڨ
	- other?..	ڨ	ڨ

Please explain YES answers from above in this space: ____
____
____
____

Institute for Accelerated RN Success, Inc. **Student Health Physical Form**

Signature of Student: ____ **Date signed:** ______________

***A photocopy or facsimile of this document shall be considered the same as the original document.*

Health Screening Examination

Physical Examination

Name: ____ **Age:** _____ **Date of Birth:** _____/_____/_____

Height __________ Weight __________ BP _______/_______ Pulse _______ Respiration _______

Vision R 20/_____ L 20/ _____ Corrected (CIRCLE): Yes No If yes, with? (CIRCLE) Glasses Contacts

COMPLETE / LIMITED	NORMAL	ABNORMAL FINDINGS	INITIALS
CARDIPULMONARY			
PULSES			
HEART			
LUNGS			
SKIN			
ABDOMINAL			
GENITALIA			
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**	**INITIALS**
NECK			
SHOULDERS			
ELBOWS			
WRISTS			
HANDS			
BACK/SPINE			
HIP/PELVIS			
KNEES			
ANKLES			
FEET			
DENTAL EXAM	**NORMAL**	**ABNORMAL FINDINGS**	**INITIALS**
GUMS AND TONGUE			
TEETH			
TMJ JOINT			

Clearance (check one): ☐ **CLEARED** ***Student has no apparent signs or symptoms of a communicable disease, which might constitute a risk of communicating disease to any person under the care of the student.***

☐ Cleared *after* completing evaluation/treatment for: ________________________

☐ **NOT CLEARED** due to: ____

Other recommendations: ____

Name of Examining Physician/ARNP: ____________________________________ Phone Number: ________________

Signature of Examining Physician/ARNP: ______________________________________ Date: ____________________