LOEWENBERG SCHOOL OF NURSING
HEALTH EXAMINATION FORM (FORM 003)

NAME: _____ U#_____BSN ( ) RN-BSN ( ) Memphis ( ) Lambuth ( )

To be completed by a licensed health care provider, such as a physician, a certified registered nurse practitioner or physician assistant prior to entering the nursing program. Additional comments may be entered on another form when necessary.

PHYSICAL EXAMINATION

	Check if WNL	Abnormality noted and comments
General appearance		
Skin		
Head & Neck		
Nose, Sinuses, Mouth, Throat & Teeth		
Lungs & Chest		
Heart		
Abdomen		
Neurologic		
Musculoskeletal		
Breasts		
Reproductive		

LABORATORY TESTING AND IMMUNIZATION REQUIREMENTS – The Hepatitis B series MUST be completed 1 month prior to beginning a clinical practicum experience. If any of these titers do not show immunity, the appropriate vaccine(s) or boosters are to be administered unless medically contraindicated. Records showing proof of immunization may be attached in lieu of completing the table below.

Required Immunizations	**mm/dd/yy**	**mm/dd/yy**	**mm/dd/yy**	**mm/dd/yy**
• DPT or Td (Diphtheria-Pertussis-Tetanus or Tetanus-Diphtheria)	#1	#2	#3	#4
• Td (Tetanus-Diphtheria)				
• Tdap (Tetanus-Diphtheria-acellular Pertussis) ***Within 10 years** **If this immunization is contraindicated please submit documentation				
• Polio				
• MMR (After first birthday)				
• Measles			* Disease Date	*** Titer Date & Result
• Mumps			* Disease Date	*** Titer Date & Result
• Rubella			* Disease Date	*** Titer Date & Result
• Hepatitis B Series (*Unless Hep. B Waiver signed)	#1	#2	#3	*** Titer Date & Result
• Varicella (chicken pox) series of two doses	#1	#2	* Disease Date	*** Titer Date & Result
• Tuberculin (PPD) Test: **within past 12 mo.** Date Read mm induration	mm			
• Chest x-ray, if PPD positive Date				
• Influenza Vaccine: **Current flu season—required for Spring admission**				

*Are there any known physical or mental health conditions or impairments that would affect the above individual from participating in the nursing program or clinical experiences in the nursing program? No ( ) Yes ( ) If so, please explain in detail on a separate form.

To my knowledge, the information supplied on this health form is accurate and complete.

_____ _____

Health Care Provider Signature/Date Health Care Provider Address

_____ _____

Health Care Provider Printed Name Health Care Provider Phone

NAME: _____ UUID_____BSN ( ) RN-BSN ( ) Memphis ( ) Lambuth ( )

Additional Comments (if applicable):

_____

Provider Signature/Date