Physical Evaluation Form

Applicant Name: _____ Date of Birth: _____

This side to be completed by Applicant

YES	No	Have you ever had:	Explain if YES
		Heart Problems	
		Rheumatic Fever	
		Epilepsy or Seizures	
		Tuberculosis	
		Hepatitis	
		Difficult breathing past moderate exertion	
		Asthma	
		High Blood Pressure	
		Fainting Spells	
		Allergy to drugs, foods, etc	
		Diabetes	
		Depression	
		Anxiety	
		Bipolar Disorder	
		Schizophrenia	
		Hearing problems	
		Back problems that prevent lifting more than 50 pounds	
		Arthritis	
		Vision problems (other than corrected by lenses)	

I have revealed my medical history truthfully and wholly. I understand that falsification or omission of information could jeopardize my application and/or subsequent standing in the Practical Nursing Program. I authorize my medical provider to give information to the Infinity College regarding my ability to participate in the practical nursing program.

_____ _____

Applicant Signature Date

HEALTHCARE PROVIDER TO COMPLETE THIS SIDE

Student Name: _____

Please check YES if the applicant's past or present medical history indicated any of the below. Explain if YES.

YES	NO	Past or Present Medical History	Explain if YES
		Chronic Illness	
		Physical disability	
		Acute illness	
		Recurring Physical concerns	
		Mental Health concerns	
		Visual Impairment	
		Hearing Loss	
		Neck, Shoulder, Back Problems	
		Unable to Distinguish colors	

Significant medical history of applicant:

_____

_____

_____

_____

ESSENTIAL FUNCTIONS OF A PRACTICAL NURSE

Lift 10-15 pounds	Frequently
Lift 26-50 pounds	Occasionally
Carry 10-25 pounds	Occasionally
Push/Pull up to 50 pounds	Occasionally
Squat/Kneel	Occasionally
Wrist Pronation/Supination	Constantly
Wrist Flexion/Extension	Constantly
Sit	Occasionally
Stand/Walk	Constantly
Crawl	Infrequently
Back Flexion	Constantly
Back Extension	Occasionally
Back Rotation	Constantly
Neck Flexion	Constantly
Neck Extension	Occasionally
Neck Rotation	Frequently
Reaching Above Shoulder	Frequently
Use of Fingers and Hands	Constantly
Repeated Bending and Reaching	Constantly

Ability for rapid Mental and Muscular Coordination Simultaneously	Constantly
Near Vision Required (Corrected lenses permitted)	Constantly
Hearing (Hearing aid permitted)	Constantly

RECOMMENDATION: From the preceding exam, this individual is capable of undertaking the demands on a healthcare provider: _____YES ____NO

Remarks:

_____

_____

_____

_____ _____

Healthcare Provider's Signature Print Healthcare Provider's Name

Address:

_____

_____

Phone: _____ Date: _____

Insert Healthcare Provider Stamp