UNITED STATES UNIVERSITY

Appendix E

MEDICAL CLEARANCE FORM

Physician/NP: We rely heavily on your history with and examination of this nursing student. We appreciate as much information as possible on history and physical examination. Thank you.

Name _____**Social Security Number (last 4)** _____

Blood Pressure (1) _____(2) _____Pulse _____ Ht. _____ Wt._____

Vision (without glasses): Right _____ Left _____(with glasses) Right _____ Left _____

Allergies _____

Clinical Exam: Check each Item in appropriate column. Elaborate as needed.

Normal Abnormal

_____H.E.E.N.T. _____
_____Pupil Size _____
_____Skin _____
_____Heart _____
_____Lungs _____
_____Abdomen _____
_____Hernia and Genitalia (males) _____
_____Neurological _____
_____Spinal Column (scoliosis, etc.) _____
_____Upper Extremities _____
_____Lower Extremities _____

Present Health Problems:

Comments/Recommendations:

Restrictions:

Required for all Nurse Practitioner Students: Rubeola Screen _____Mumps Screen _____
(May attach records/reports) Results (+/-) and Date Results (+/-) and Date

Rubella Screen_____ Varicella Screen_____ Tdap shot date _____
Results (+/-) and Date Results (+/-) and Date

TB PPD (1) _____ TB PPD (2) _____ (OR) CXR _____
Date Read and Result Date Read and Result Result and Date

☐ Yes ☐ No **The student named above is physically and mentally able to perform duties of a nursing student.**

Provider's Address_____**City**_____**State**_____**Phone:** _____

Provider's Signature_____**Date:**_____

Please provide provider/clinic stamp.