ALBUQUERQUE PUBLIC SCHOOLS
PRACTICAL NURSING PROGRAM
PHYSICAL EXAMINATION FORM

DATE:_________________

TO PARENTS and CARE PROVIDER: The APS Practical Nursing Program must have the student's health history and provider's recommendations in order for the student to participate in this strenuous two year nursing program. The program requires the student to be in excellent mental and physical health. Please fill in the information requested below for our health records. The student's parents or guardian needs to complete the PARENTS/GUARDIAN REPORT TO THE SCHOOL, and then the healthcare provider needs to complete the PROVIDER'S REPORT TO THE SCHOOL. The reports can then be emailed, dropped off, or mailed to the Career Enrichment Center Practical Nursing Program.

PARENT/GUARDIAN REPORT TO THE SCHOOL

Student's name	DOB	Gender
Name of Physician	Phone	
Name of Dentist	Phone	

Medication(s) Student is Taking:	
Known Allergies to Medications/Foods:	

RECORD OF ILLNESS: Check appropriate space if there has been an occurrence and state year of occurrence.

RECORD OF ILLNESS	CHECK IF APPLICABLE	YEAR OCCURRED
Bone or Joint Trouble		
Diabetes		
Heart Trouble		
Kidney Trouble		
Rheumatic Fever		
Back Trouble		
Asthma		
Ear Trouble		
Nose or Throat Trouble		
Fainting Spells		
Seizures/epilepsy		
Frequent Colds or Bronchitis		
Muscle Weakness or Paralysis		
Speech Disorder		
Tuberculosis		
Vision Difficulty		
Hearing Difficulty		
Behavior Difficulty		
Complications following Illnesses		
Injuries or Operations		

Further remarks or explanation of any of the above:
____
____
____

Parent's Signature____

ALBUQUERQUE PUBLIC SCHOOLS
PRACTICAL NURSING PROGRAM
PROVIDER'S REPORT TO THE SCHOOL

Date:___________________

Student's name	DOB	Gender

Vision R20/ _____L 20/ ______ Corrected Y___N___

Medical	Normal	Abnormal	Findings/Comments
General Appearance			
Eyes/ears/nose/throat			
Hearing			
Heart			
Pulses			
Lungs: Auscultation			
Abdomen			
Skin			
Musculoskeletal			
Can lift 50 pounds			

Please check "Yes" or "No" to the questions below. If "Yes" is checked, please specify your recommendations to the school at the bottom of the page.

	NO	Yes
1. Is the student subject to conditions, which make for classroom emergencies, e.g. epilepsy, fainting, diabetes, asthma or allergies?		
2. Is there any mental, emotional, or physical condition for which the student should remain under your periodic observation?		
3. Is there any physical, emotional, or mental problem, including nutritional status, which would limit the student's participation in: **Classroom Activities**		
Nursing Activities		
Medication Distribution		
4. Does this student have any other medical problems which could keep the student from performing nursing duties?		

Recommendations:____
____
____

I verify that I have reviewed the Medical History information provided and after exam, clear the student for the following:

The nursing student applicant **MAY** participate in the following:
ALL NURSING SCHOOL ACTIVITIES/CLINICAL

The nursing student applicant IS **NOT CLEARED** FOR PARTICIPATION

PROVIDER'S SIGNATURE ______________________________________**Date**_______________

NAME OF PROVIDER_________________________________ **__MD __DO __NP __PA**
CONTACT NUMBER _________________________________