CAPITAL AREA SCHOOL OF PRACTICAL NURSING

2201 TORONTO ROAD
SPRINGFIELD, ILLINOIS 62712-3803
www.caspn.org

PHYSICAL EXAMINATION

(MUST BE COMPLETED BY A PHYSICIAN)

APPLICANTS ARE **NOT** TO WRITE ON THIS FORM

NAME________________________________ **DATE**___________ **Age**__________

When did applicant last have a complete physical examination?______________

Past Illnesses____

Past Surgery____

Is applicant currently under care for any specific illness or injury? _____

Please describe.____

List any medications applicant is currently taking.________________________

____

General Physical Health: **Above Average**____ **Average**_____ **Below Average**_____

General Mental Health: **Above Average**____ **Average**_____ **Below Average**_____

PHYSICAL FINDINGS:

Eyes: Vision: R_______ **L**_______ **With Corrective Lenses: R**______ **L**______

Ears: Obstruction: R_________ **L**_________ **Hearing: R**_________ **L**_________

Tonsils_________________ **Sinuses**__________________ **Nose**________________

Neck/Thyroid____________ **Lymph Glands**_____________ **Skin**________________

Breasts: R________ **L**________ **Abdomen**_____________ **Hernia**______________

Extremities_______________ **Feet**________________ **Posture**________________

Orthopedic Condition(s)____

Hemorrhoids_____________ **Varicose Veins**___________ **Edema**_______________

Chest________________ **Lungs**________________ **Respirations**_______________

Heart: Rhythm: Regular__________ **Irregular**___________ **Murmurs**__________

Rate: Resting_________________ **After Exercise**__________________

Blood Pressure_________________ **Height**______________ **Weight**______________

(OVER)

ALL OF THE BELOW ITEMS ARE REQUIRED BEFORE ADMISSION

BLOOD WORK

Date:___________ WBC_______ Hematocrit (HCT)_______ Hemoglobin (HGB)_______

URINALYSIS:

Date:___________ Specific Gravity______ Sugar______ Albumin______ pH_______

THE FOLLOWING IMMUNIZATIONS ARE MANDATORY BEFORE ENTERING SCHOOL:

PPD or chest x-ray within 12 months:Date______________ Result________

Rubella Titre/Vaccination:#1_____________ #2______________

Rubeola Titre/Vaccination:#1_______________

Hepatitis B Titre/Vaccination:#1__________ #2__________#3__________

Varicella:Date of Titre or Dx___________, #1____________ #2_____________

Do you believe this individual is in satisfactory physical and emotional condition to enter our practical nursing program? Yes______ No______

If no, why?____

____

Other remarks and/or recommendations:____

____

ALL INFORMATION ON THIS FORM IS REQUIRED, OR THE EXAMINATION WILL BE CONSIDERED INCOMPLETE.

Physician's Signature__________________________________

Address__________________________________

City, State, Zip__________________________________

Date__________________________________

Rev.01/07,01/08