



Gadsden Technical College

SCHOOL OF PRACTICAL NURSING

201 Martin Luther King Jr., Blvd.* Quincy, Florida 32351* 850-875-8324(Main)* 850-875-7297(fax)*www.gadsdentech.org

MEDICAL HISTORY

TO BE COMPLETED BY: APPLICANT

NAME: _____ AGE: _____ DOB: _____ DATE: _____

Please indicate if you have a history of the following health problems and the approximate dates or age when they occurred.

DISEASE	YES	DATE/ AGE	NO
Diphtheria			
Whooping Cough			
German Measles			
Chicken Pox			
Scarlet Fever			
Anemia			
Epilepsy			
Tetanus (Lockjaw)			
Rheumatic Fever			
Measles			
Mumps			
Smallpox			
Polio			
Sickle Cell Anemia			
Seizures			
Diabetes	<i>What Treatment?</i>		

Do you have any allergies (food, drugs, etc.)? _____ Yes _____ No
If yes, name. _____

Any history of serious injuries? _____ Yes _____ No
If yes, explain. _____

Any history of major surgery? _____ Yes _____ No
If yes, explain. _____

List all medications you are currently taking and reason for taking each.

MEDICATION	REASON

PROGRAM ESSENTIAL TASKS

Health related occupations are demanding, both physically and emotionally. Before entering a program in the health field, it is important to review the following tasks which have been established. Their performance is essential for success in the program.

Mental and Emotional Requirements:

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Ability to cope with a high level of stress |
| <input type="checkbox"/> | <input type="checkbox"/> | Ability to make fast decisions under high pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Ability to cope with the anger/fear/hostility of others in a calm manner |
| <input type="checkbox"/> | <input type="checkbox"/> | Ability to interpret audible sounds of distress |
| <input type="checkbox"/> | <input type="checkbox"/> | Ability to manage altercations |
| <input type="checkbox"/> | <input type="checkbox"/> | Ability to concentrate |
| <input type="checkbox"/> | <input type="checkbox"/> | Ability to cope with confrontation |
| <input type="checkbox"/> | <input type="checkbox"/> | Ability to handle multiple priorities in a stressful situation |
| <input type="checkbox"/> | <input type="checkbox"/> | Ability to assist with problem resolution |
| <input type="checkbox"/> | <input type="checkbox"/> | Ability to work alone |
| <input type="checkbox"/> | <input type="checkbox"/> | Ability to demonstrate a high degree of patience |
| <input type="checkbox"/> | <input type="checkbox"/> | Ability to adapt to shift work |
| <input type="checkbox"/> | <input type="checkbox"/> | Ability to work in areas that are close and crowded |

Please explain any other significant health issues: _____

I certify by my signature that the above information is true, complete, and accurate.

APPLICANT SIGNATURE

DATE

Original to be retained with Gadsden Technical College, School of Practical Nursing.

Mission Statement

The mission of Gadsden Technical College is to recognize the worth and potential of each student. We are committed to providing opportunities for basic and advanced instruction in a conducive learning environment. The College encourages academic and technical curiosity, innovation and creativity by integrating applied academic skills in all occupational areas. We strive to instill the attitudes and skills necessary to produce motivated, self-sufficient individuals who are able to function effectively in our ever-changing, complex society.



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PHYSICAL EXAMINATION

TO BE COMPLETED BY: HEALTH CARE PROVIDER

NAME: _____ DATE: _____

(Documentation of the following information is required).

MEDICAL HISTORY VERIFICATION

IMMUNIZATIONS/BOOSTER	DATE(S) RECEIVED	COMMENTS/FOLLOW-UP
Tetanus		
MMR (Measles, Mumps, Rubella) Vaccine X2		
Hepatitis B Vaccine Series (3)		
Varivax X2 or Varicella (<i>Titer</i>)		
Flu Vaccine		
OTHER		
TB (Tuberculosis Test. Blood Test Preferred)		Results:
Chest X-ray (if previous positive TB test)		
COVID Vaccines		

***Immunization/shot record must be submitted with this physical examination

PHYSICAL EXAMINATION

		Normal	Abnormal	COMMENTS (for Abnormal)
1.	EYES: (Discharge, Strabismus, Pterygium, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
2.	EARS: (Discharge, Evidence of deafness, middle ear or mastoid disease, drums absent, perforated, dull, retracted.)	<input type="checkbox"/>	<input type="checkbox"/>	
3.	NOSE: (Obstruction, evidence of chronic sinus infection)	<input type="checkbox"/>	<input type="checkbox"/>	
4.	THROAT: (Tonsils enlarged or removed)	<input type="checkbox"/>	<input type="checkbox"/>	
5.	MOUTH: (Missing teeth, pyorrhea, caries, abnormal tongue or palate)	<input type="checkbox"/>	<input type="checkbox"/>	
6.	NECK: (Thyroid enlargement)	<input type="checkbox"/>	<input type="checkbox"/>	
7.	BREAST: (Abnormal discharges, nodules, masses)	<input type="checkbox"/>	<input type="checkbox"/>	
8.	LUNGS: (Conformation, respiratory movement, breathing sounds)	<input type="checkbox"/>	<input type="checkbox"/>	
9.	ARTERIES: (Peripheral pulsation)	<input type="checkbox"/>	<input type="checkbox"/>	
10.	HEART: (Enlargement, thrills, murmurs, rhythm)	<input type="checkbox"/>	<input type="checkbox"/>	
11.	VEINS: (Varicose, location, severity)	<input type="checkbox"/>	<input type="checkbox"/>	
12.	ABDOMEN: (Scars, masses, palpable liver or spleen, tenderness)	<input type="checkbox"/>	<input type="checkbox"/>	
13.	HERNIA: (Type, severity)	<input type="checkbox"/>	<input type="checkbox"/>	
14.	GENETALIA/MALE: (Varicocele, prostate, ect...)	<input type="checkbox"/>	<input type="checkbox"/>	

		Normal	Abnormal	COMMENTS (for Abnormal)
15.	GYNECOLOGICAL: (Significant abnormal condition, severity)	<input type="checkbox"/>	<input type="checkbox"/>	
16.	ANO-RECTAL: (Hemorrhoids, prolapse, fissure, fistula)	<input type="checkbox"/>	<input type="checkbox"/>	
17.	NERVOUS SYSTEM: (Gait, reflexes, sensation, seizure)	<input type="checkbox"/>	<input type="checkbox"/>	
18.	PSYCHIATRIC: (Mood, abnormal behavior, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
19.	SKIN: (Lesions, scars, abnormalities, extent and severity)	<input type="checkbox"/>	<input type="checkbox"/>	
20.	MUSCULOSKELETAL: (Congenital or acquired impairment, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
21.	GOOD HEALTH HABITS	<input type="checkbox"/>	<input type="checkbox"/>	
22.		(Other)		
23.		(Other)		

PROGRAM ESSENTIAL TASKS

Health related occupations are demanding, both physically and emotionally. Before entering a program in the health field, it is important to review the following tasks which have been established. Their performance is essential for success in the program.

To be completed and signed by the Health Care Provider ONLY:

Physical Requirements:

- Ability to perform repetitive tasks
- Ability to walk the equivalent of five miles per day
- Ability to reach above shoulder level
- Ability to project audible verbal communications at a distance of 4 feet
- Ability to demonstrate high degree of manual dexterity
- Ability to work with chemicals and detergents
- Ability to tolerate exposure to dust and/or odors
- Ability to grip
- Ability to distinguish colors
- Ability to lift a minimum of 25 lbs. & maximum of 100 lbs.
- Ability to bend knees
- Ability to sit or stand for long periods of time
- Ability to perform CPR
- Vision within normal limits
- Hearing with normal limits

ADDITIONAL COMMENTS: _____

I have completed the physical examination, reviewed the health history and found this person to be free of illness that may affect his/her work, met the above requirements, and is physically and mentally able to provide patient care in a healthcare setting.

Signature and Title of Examiner

Date

Office Stamp (if applicable)

It is my recommendation that this person does **not participate** in the Program at this time.

Signature and Title of Examiner

Date



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