

SOUTHWESTERN MICHIGAN COLLEGE SCHOOL OF NURSING
58900 CHERRY GROVE ROAD-DOWAGIAC, MI 49047

HEALTH RECORD/APPLICANT'S FORM

INSTRUCTIONS TO THE APPLICANT: This form must be completed, signed and returned to Student Services. All information is confidential and should be as complete as possible. This information will be used in the best interest of the applicant and patient safety.

Please **PRINT IN INK or TYPE**. You should complete this form. Your physician should complete the other form. Please make that you and your physician sign in the proper places.

PART ONE--TO BE COMPLETED BY THE APPLICANT DATE _____

Name _____ Sex M F DOB _____
(Last) (First)

Street _____ SSN _____

City _____ State _____ Zip _____

Current Phone Number (hm) _____ (wk) _____

Current Medications _____

Current conditions under MD's Care _____

Sensitivities or Allergies _____

Physical Impairments _____

Do you have a lifting weight restriction-if yes, please explain

HISTORY Have you had: (check each item)
Yes No If yes, explain

Tuberculosis	_____
Diabetes	_____
Epilepsy	_____
Cancer	_____
Asthma	_____
Heart Disease	_____
High Blood Pressure	_____
Eye or Ear Problems	_____
Shortness of Breath	_____
Kidney Disease	_____

Yes No If yes, explain

Fainting or Dizzy Spells _____
Color Blindness _____
Contact Lenses _____
Learning Disabilities _____
Severe Headaches _____
Anxiety Reactions _____

PRINT name of physician who will perform your examination:

Name _____

Street _____

City _____ State _____ Zip _____

Phone _____

To the best of my knowledge, the above information is correct. I understand that misinformation may result in dismissal.

Applicant's Signature _____

Date _____