SOUTHWESTERN MICHIGAN COLLEGE SCHOOL OF NURSING
58900 CHERRY GROVE ROAD-DOWAGIAC, MI 49047
HEALTH RECORD/PHYSICIAN'S FORM

TO THE PHYSICIAN: The applicant has been asked to complete the history on the attached copy. Please review for accuracy. Using the following form please make the necessary examinations. This information will be used in the best interest of the applicant and patient safety. This applicant is being considered for a health occupation; therefore, we are concerned about physical stamina.

Applicant's Name_____

Ht_____ Wt_____ BP_____ P_____ R_____ T_____

Check each item:

Normal	Abnormal		Nature of Abnormality
☐	☐	Skin	_____
☐	☐	Head/Neck/Thyroid	_____
☐	☐	Eyes/Vision	_____
☐	☐	Ears/Hearing	_____
☐	☐	Nose/Sinuses/Mouth	_____
☐	☐	Throat/Nodes	_____
☐	☐	Chest/Breasts	_____
☐	☐	Lungs	_____
☐	☐	Heart	_____
☐	☐	Abdomen	_____
☐	☐	Extremities/Joints	_____
☐	☐	Vascular	_____
☐	☐	Neuro/Reflexes	_____
☐	☐	Mental Status	_____

IMMUNIZATION OR PROOF OF IMMUNITY. (Must be up to date.)

Month/Day/Year

TB test or CXR Neg_____Pos_____ _____
(Mantoux only) Must be done yearly: CXR is done every 2 years

Tetanus Within ten years _____

Rubella Lab evidence or vaccine _____

Rubeola Lab evidence or two vaccines if born after 1957_____
1st 2nd

Hepatitis B Series Initiated _____
(applicant may defer this vaccine until admitted)

Chicken Pox (Varicella) Proof of disease or immunity _____

Is this applicant subject to any physical limitations? No☐

Yes☐Explain, if yes_____

Additional comments regarding the applicant's physical and/or mental health?

_____

Physician's Signature_____ Date_____

Address_____

Form/Medical Form

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