LAMAR STATE COLLEGE-ORANGE
PHYSICAL EVALUATION FORM - MEDICAL HISTORY

This page of the Lamar State College-Orange Physical Evaluation Form is to be completed in its entirety by the student.

____________________	LVN / RN (circle one)
Today's Date	**LSCO Program of Study**

____________________ ____________________ __________
Last Name **First Name** **Middle Initial**

____________________ ____________________
Date of Birth **Phone Number**

____________________ ____________________ __________
Address **City / State** **Zip Code**

____

Health History

Please indicate if you have or have had any of the following health problems.

	Disease or Symptom	✓		Disease or Symptom	✓		Disease or Symptom	✓
1	allergies		15	dental		29	malaria	
2	anemia		16	diabetes		30	measles (rubeola)	
3	anxiety		17	dizziness		31	monoucleosis (EBV)	
4	arthritis		18	drug (including alcohol) problem		32	mumps	
5	asthma		19	eating disorder		33	neurological disorder	
6	back problems		20	eye disease or injury		34	parasites	
7	blood disorder		21	frequent headaches		35	pneumonia	
8	bone or joint problem		22	german measles (rubella)		36	psychiatric illness	
9	cancer		23	GI disorders/ including hernia		37	scarlet fever	
10	cardiac problems		24	hepatitis (specify type)		38	sexually transmitted disease	
11	chicken pox (varicella)		25	high blood pressure		39	surgery (any)	
12	cholera		26	hospitalization (any)		40	syphillis	
13	chronic bronchitis		27	inflammatory bowel disease		41	tuberculosis	
14	depression		28	kidney disease		42	typhoid fever	

EXPLANATION OF ABOVE

____

____

SOCIAL HISTORY - please circle response

a. **Tobacco**: Smoking (**yes / no**) Oral/Chew/Spit (**yes / no**) **Amount & Frequency**: __________
b. **Alcohol**: (**yes / no**) **Amount & Frequency**: __________
c. **Exercise**: (**yes / no**) **Sport/Activity** __________ **Frequency** __________
d. **Seat Belt Use**: (**yes / no**) **If yes, what percentage of the time.** __________

MEDICATIONS (Including prescribed, over-the-counter, and/or herbal)

a. ____________________
b. ____________________
c. ____________________
d. ____________________

Do you have any allergies to medications, food, or environmental sources? **(yes / no)** If yes, please describe

____

____

Are there any health problems in the immediate family? (parents or siblings) (**yes / no**) If yes, please describe __________

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LAMAR STATE COLLEGE-ORANGE

PHYSICAL EVALUATION FORM - MEDICAL HISTORY - Page 2

This page of the Lamar State College-Orange Physical Evaluation Form is to be completed in its entirety by a physician, physician assistant or certified nurse practitioner. Physical exam results must be current within one year of any clinical experience.

Height: ________ **Weight:** ____________ **Sex (F / M)** **Resting Pulse** ____________________

Blood Pressure ____________ **Uncorrected Vision: R** ________/20 **L** _______/20
Corrected Vision: R ________/20 **L** _______/20

Please examine and comment on the following systems.

		Normal	Abnormal (comment)
1.	Head, Eyes, Ears, Nose, and Throat		
2.	Respiratory		
3.	Cardiovascular		
4.	Gastrointestinal		
5.	Genito-urinary		
6.	Musculoskeletal		
7.	Metabolic/Endocrine		
8.	Neuropsychiatric		
9.	Skin		

LAB: Please include the results of any lab work that you routinely perform or feel is indicated. ____________________

1. For each of the Essential Functons listed below, please refer to the attached explanatory document and indicate whether the student is able to perform the task by checking the appropriate box.

Essential Function		Yes	No	If no, please comment.
1.	Sensory			
a.	Visual			
b.	Auditory			
c.	Tactile			
d.	Olfactory			
2.	Communication/Interpersonal Relationships			
3.	Cognitive/Critical Thinking			
4.	Motor Function			
5.	Professional Behavior			

2. Based on the findings in the examination, is the student able to participate in all activities required in the indicated health education program? **(Please circle appropriate response.)** **Yes** **No**
3. Please identify any restrictions to be placed on this student's participation in the indicated health education program? ____________
4. Is this student free of infectious disease? **(Please circle appropriate response.)** **Yes** **No**

General Comments: ____

HEALTHCARE PROIVDER SIGNATURE: The information on this form must be filled in and signed by a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, or a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nursing. Examination forms signed by any other health care practitioner, will not be accepted.

Name (print/type): ______________________ **Date of Examination:** ____________
Address: ______________________________________
Phone Number: ____________________
Signature: ______________________________

Signature of Student verifying that the information on the front and back of this Lamar State College-Orange Physical Evaluation Form is accurate.

Signed: ______________________________ **Date:** ______________

Lamar State College-Orange

Nursing Department

Immunizations Required by State Law/Clinical Facilities

COPIES OF IMMUNICATION CARDS ARE ACCEPTABLE

Name: ______________________ **Date of Birth:** ______________________

Measles (Rubeola)*:	
A. Two doses of measles vaccine on or after their first birthday and at least 30 days apart **(**See note) OR**	**Date # 1** ________ (mm/dd/yy) **Date # 2** ________ (mm/dd/yy)
B. Serologic test positive for measles antibody *****See note**	**Date:** ________ (mm/dd/yy) **Result:** ________
Mumps*:	
A. Two doses of mumps vaccine on or after their first birthday **OR**	**Date # 1** ________ (mm/dd/yy) **Date # 2** ________ (mm/dd/yy)
B. Serologic test positive for mumps antibody *****See note**	**Date:** ________ (mm/dd/yy) **Result:** ________
Rubella*:	
A. One does of Rubella vaccine on or after their first birthday **OR**	**Date:** ________ (mm/dd/yy)
B. Serologic test positive for Rubella antibody ***** See note**	**Date:** ________ (mm/dd/yy) **Result:** ________

***Measles, Mumps, Rubella (MMR)/Varicella vaccines if not given on same day MUST be 30 days apart.**

****Combined MMR Vaccine is vaccine of choice if recipients are likely to be susceptible.**

*****Must be the date of diagnosis or test collection; not when primary care provider signed immunization form.**

Hepatitis B **(HVB Series) must show proof of:**	
A. Give 3-dose series (dose #1 now, #2 in 1 month, #3 approximately 5 months after #2.) **If a student does not follow the afore-mentioned guidelines when receiving the 3-dose series, the student may need to submit to a serologic test. ***** See note**	**Date # 1** ________ (mm/dd/yy) **Date # 2** ________ (mm/dd/yy) **Date # 3** ________ (mm/dd/yy)
B. Serologic test positive for Hepatitis B antibody ***** See note**	**Date:** ________ (mm/dd/yy) **Result:** ________

*****Must be the date of diagnosis or test collection; not when primary care provider signed immunization form.**

*******If anti-HBs is at least 10mIU/mL (positive), the patient is immune. No further serologic testing or vaccination is recommended.**

If anti-HBs is less than 10 mIU/mL (negative), the patient is unprotected from hepatitis B virus (HBV) infection; revaccinate with a 3-dose series. Retest anti-HBs 1-2 months after dose #3. If anti-HBs is positive, the patient is immune. No further testing or vaccination is recommended. If anti-HBs is negative after 6 doses of vaccine, patient is a non-responder.

Name: ______________________ Date of Birth: ______________________

Varicella* **must show proof of:**	
A. Two doses of varicella vaccine on or after their first birthday and at least 30 days apart ****** OR**	**Date # 1** __________ (mm/dd/yy) **Date # 2** __________ (mm/dd/yy)
B. Serologic test positive for Varicella antibody **OR ***See note**	**Date:** __________ (mm/dd/yy) **Result:** __________
C. Physician documented history or diagnosis of Varicella ***** See note**	**Date Disease Occurred** __________ (mm/dd/yy) **Documented history after September 1, 1991 must have a month, day, and year.**

***Measles, Mumps, Rubella (MMR)/Varicella vaccines if not given on same day MUST be 30 days apart.**
*****Must be the date of diagnosis or test collection; not when primary care provider signed immunization form.**
******Only one dose of Varicella vaccine is needed if the student received first dose before the age of thirteen (13).**

New Requirement: Proof of Pertussis is now required by clinical affiliates.

Tdap	
Vaccine required once only: Note: Tdap booster every 10 years.	**Date** __________ (mm/dd/yy)

Tb Skin Test - Required Annually	
Tb Skin Test Administered	**Date (mm/dd/yy):** __________
Tb Skin Test **Results & Date Read (mm/dd/yy)**	**Q Positive**_____**mm Q Negative**_____**mm Date** _____
Chest X-ray (required **IF** skin test positive) Must provide signed documentation of results	**X-ray results:** __________ **Date (mm/dd/yy):** __________

Seasonal Flu Shot (Taken after October 1)	**Date** __________ **(mm/dd/yy)**

Physician or Approved Licensed Health Professional Information:

Printed Name ______________________

Address ______________________

Signature of Primary Care Provider[%] ______________________

Date : ______________________

[%] **- Validates all information on page one and two of the Immunizations Required by State Law/Clinical Facilities form.**
Date of signature must be after last immunization or additional immunizations must be signed and dated separately.

+Vaccines administered after September 1, 1991, shall include the MM/DD/YY each vaccine was given.

NOTE: Students will be required to get a seasonal flu shot.