

Nursing Student History and Physical

All Moraine Valley Community College Nursing students are required to complete and return this medical form. Admission to the program is not based on the content of this form, but history and physical records must be on file prior to clinical assignment by the deadline date specified by the program. Health insurance is mandatory and must be carried by the student. **PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS.** In the event you enroll in another Moraine Valley Health Science Program, you are responsible for maintaining this information and submitting it to subsequent programs. NO copies will be created and forwarded by college representatives.

Part I – To be completed by the Student

MVConnect Student ID Number _____

Miss Mrs. Ms. Mr.

Name _____
Last First Middle Maiden

Address _____

City _____ State _____ ZIP Code _____

Telephone (_____) _____ Date of Birth _____

Student's Health History (to be completed by Student)

Do you have any physical limitations? Yes No

If yes, specify. _____

Do you wear glasses or contact lenses? Yes No

Have you ever experienced difficulty hearing? Yes No

If yes, specify. _____

Do you have a history of:

Tuberculosis Yes No Infectious Mononucleosis Yes No Diabetes Yes No

Epilepsy Yes No Heart Disease Yes No

I certify that this information is true to the best of my knowledge.

Signature _____ Date _____



Part II – To be completed by Examining Physician

Please list any prescribed medications/treatments the student is receiving.

On the basis of your history and physical examination, is it your professional opinion that this student is capable of participating in a nursing program?

Yes No

What restrictions would you advise? _____

Any allergies? _____

Drug sensitivities? _____

Is the student free of communicable disease? Yes No

Comments _____

Is the student color blind? Yes No

Signature of Examining Physician _____

Office Address _____ Office Telephone (____) _____ Date of Examination _____

Part III – To be completed by the Student

Notify in emergency (parent, guardian or spouse)

Name _____ Relationship _____

Home Telephone (____) _____ Cell/Mobile Telephone (____) _____

Address _____ City _____ State _____ ZIP Code _____

Family Physician _____

Address _____ City _____ State _____ ZIP Code _____

Office Telephone (____) _____ Office Email or Website _____

I do hereby authorize release of the information contained in this student history and physical form to clinical site personnel, and that emergency care be given without undue delay to render whatever medical treatment is deemed desirable for the student named on this History and Physical Form.

Student Signature* _____ Date _____

Student Name _____ Relationship _____

I have read this report and recommendations of the physician.

Student Signature* _____ Date _____

Student Name _____

** Student's signature is required if the student is of legal age. A parent's signature is required if the student is not married and is under 18 years of age.*

(Confidential when completed.)

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