RANGER COLLEGE NURSING PROGRAM
300 Early Blvd, Suite 105
Early, Texas 76802
Phone: 325-203-5013
rangercollege.edu/academics/allied-health

Physical Examination / Medical History

☐ **LVN** – Submission Deadline: May 15 for Fall Admission

☐ **RN** – Submission Deadline: May 15th for Fall Admission

☐ **LVN to RN BRIDGE** – Submission Deadline: Oct 1st for Spring Admission

Applicant Information (Please print)

Date of Exam: _____

First Name: _____ Last Name: _____

Date of Birth: _____ Phone: _____

Address: _____ City, State, Zip _____

Health Questionnaire to be completed by Applicant

☐ No	☐ Yes	Do you have any physical limitations that would affect your ability to lift, turn or transfer patients?
☐ No	☐ Yes	Do you have any limitations in use of your senses, such as in sight or hearing, which would limit your ability to practice a health profession?
☐ No	☐ Yes	Do you have any other condition that might interfere with your ability to practice in the health professions?

***If you answered "yes" to any of the above, please explain your limitations in detail:**

List any medications and purpose for medications you take on a regular basis or have taken frequently this year:

Applicant Signature: _____ Date: _____

PHYSICAL EXAMINATION FORM

Health Questionnaire <u>to be completed by Physician</u>

Applicant Name: _____

General Appearance: _____

Height: _____ Weight: _____ B/P: _____

Glasses: _____ Corrective Lenses: _____ Date of last visual exam: _____

Normal	Assessment	Abnormal	Describe any abnormality in detail
	Eyes, ears, nose, and throat		
	Mouth, teeth, neck		
	Thyroid		
	Heart & vascular		
	Lungs		
	Abdomen & viscera		
	Hernia		
	Scars		
	Neck & vertebrae		
	Genitalia		
	Pelvis (pap smear, if indicated)		
	Extremities		
	Skin		
	Neurological		
	Laboratory Data: Name/Results		

Based upon your physical examination of the applicant: ***(Please check NO or YES)***

☐NO ☐YES Is the applicant free of any restrictions? If "NO" please describe:

☐NO ☐YES Is the applicant free of ANY PHYSICAL LIMITATIONS that would affect their ability to lift, tum or transfer patients? If "NO" please describe:

☐NO ☐YES Is the applicant able to see and hear adequately to practice a health care profession? If "NO" please describe:

☐NO ☐YES Is the applicant free of any pathological conditions, either physical or mental, that would interfere with the practice of a health profession? If "No" please describe:

PHYSICIAN RECOMMENDATIONS:

PRINTED NAME of Physician/ Nurse Practitioner _____

SIGNATURE of Physician/ Nurse Practitioner _____

Address: _____

Phone: _____ Date: _____

Applicant Signature: _____ Date: _____