RANGER COLLEGE NURSING PROGRAM

300 Early Blvd, Suite 105, Early, Texas 76802
Skills Lab: 3201 Coggin, Brownwood, Texas, 76801

Web link: rangercollege.edu/nursing-programs

PHYSICAL EXAMINATION / HISTORY

_____ **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 & purpose for medications you take on a regular basis or have taken frequently this past year:

Applicant Signature ____

Health Questionnaire to be completed by Physician

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	
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, turn or transfer patients?
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 ____________________