



## RANGER COLLEGE NURSING PROGRAM

300 Early Blvd, Suite 105, Early, Texas 76802

Skills Lab: 3201 Coggin, Brownwood, Texas, 76801

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Web link: [rangercollege.edu/nursing-programs](http://rangercollege.edu/nursing-programs)

### PHYSICAL EXAMINATION / HISTORY

\_\_\_\_\_ LVN Submission Deadline: May 15th

\_\_\_\_\_ 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	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: \_\_\_\_\_