Miami University Department of Nursing
Student Physical Form

Student information to be completed and signed by student prior to physical exam.
All students must submit completed form by due date. PLEASE PRINT LEGIBLY IN DARK INK!

Name _____ MU Unique ID _____
Last First Middle Maiden (if applicable)

Birth Date _____ Phone _____ Address _____
(Include area code) Street City State Zip

Emergency Contact Name(s) _____ Phone(s) _____
(Include area code)

Family Physician _____ Phone _____
Name Address (Include area code)

Please list any allergies (including medications) and reactions _____

Please list current over the counter and prescription medications and dosage (including oral contraceptives) _____

_____

Please list any major illnesses (medical, surgical, or psychiatric) hospitalizations and operations _____

_____

I have personally supplied the information above and attest that it is accurate and true to the best of my knowledge.

Student Signature _____ Date _____

Medical Exam: To be completed and signed by health care provider after student information section completed
The Department of Nursing requires medical information that may help us in protecting this individual as a student nurse. Confidential information may be sent directly to the office of the Nursing Chairperson.

Date of Exam _____ Weight _____ Height _____ B/P _____

Corrected vision: Right 20/_____ Left 20/_____ Color vision normal? Yes No

	Normal	Abnormal	Description or Comments
Hearing*			
Head, Ears, Nose, Throat			
Musculoskeletal			
Respiratory			
Metabolic/Endocrine			
Cardiovascular			
Neuro-Psychiatric			
Gastrointestinal			
Skin			
Eyes (other than acuity)			
Dental			
Genitourinary*			
Lymphatic System			

**General screening questions can be used*

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To successfully meet the objectives of nursing courses, students must be able to function safely in the clinical setting.
Please verify that the student possesses the following functional abilities. Circle YES or NO.

YES/NO	Sufficient physical ability (minimal impairment of upper and lower extremities) to perform such skills as bending and squatting, lifting patients, transferring patients out of bed to a stretcher or chair, moving patients in bed, pushing equipment, being on their feet for 8-10 hours, performing CPR.
YES/NO	Sufficient hearing ability with or without auditory aids to understand the normal speaking voice without viewing the speaker's face (to ensure that the nurse will be able to attend to patient's call for help).
YES/NO	Visual acuity with or without corrective lenses to identify patient abnormalities such as cyanosis and pallor and to be able to see to dispense medications accurately.
YES/NO	Sufficient speaking ability to be able to question the patient about their condition and to relay information about the patient verbally to others.
YES/NO	Sufficient manual dexterity to draw up solutions in a syringe, prepare medications and administer IV fluid or perform treatments.
YES/NO	Sufficient emotional stability to exercise sound judgment and to react and manage a crisis such as a need for CPR or suicidal intervention.

Students who do not meet these criteria should seek counseling from the Office of Disability Services to determine if there are accommodations that can be made. Thank you for your assistance in assuring the safety of our students and their patients.

Medical Professional's Signature _____ Date _____

Printed Medical Professional's Name _____ Phone _____
(Include area code)

Address _____

Please load both sides of the form. The form Must include both student and medical professional's signatures.
Student must be seen by a physician at least once per year.