Applicant Name (please print): _____

HEALTH EVALUATION FORM

Directions for Health Care Provider (Physician, Nurse Practitioner or Physician Assistant)

1. A complete health history and physical examination is required for all individuals who are submitting an application to the ISU School of Nursing baccalaureate program.
2. Please complete the Health Care Provider Statement.
    a. Record all requested information directly onto the form.
    b. Attachments, such as lab reports and/or copies of health records are not an acceptable substitution for completion of the form.
3. Signature of health care provider with date is required on the form.

I have obtained a health history and performed a complete physical examination.

_____Yes _____No

If no, please explain:

In my opinion, based on my assessment, the applicant has no physical, cognitive, and/or sensory limitations, as defined in Appendix A, (such as vision, hearing, speech, touch, smell, movement, lifting) that would prevent him/her from fully participating in the School of Nursing Program, or providing safe nursing care.

_____Yes _____No

If no, please explain and include:

- Further diagnosis and treatment required.
- Verification statement that the applicant is able to provide care for patients in all health care settings.

Health Care Provider Name (Please print): _____

Title:_____

Address: _____

Phone: _____Fax:_____

Signature:_____Date:_____

Health Evaluation Form: Appendix A

PHYSICAL, COGNITIVE AND SENSORY REQUIREMENTS FOR STUDENTS

Each applicant/student must meet objectives and competencies in the following areas in order to be admitted and continue in the nursing program:

Vision
The applicant/student must be able to:

- Make visual observations of patient's status
- Detect unsafe environmental conditions
- Possess visual acuity of near clarity of vision at 20 inches or less and far clarity of vision at 20 feet or more

Hearing
The applicant/student must be able to:

- Hear spoken verbal communications from others
- Hear sounds used for patient assessment such as breath sounds, blood pressure, apical pulse, and other sounds that would indicate changes in the patient's physiological status

Speech
The applicant/student must be able to:

- Utilize clear, effective speech when communicating with patients, families and health care team

Touch
The applicant/student must be able to:

- Possess the ability to sufficiently feel patient pulses, skin temperature and other important signs of changes in patient's physiological status

Smell
The applicant/student must be able to:

- Detect odors that indicate changes in the patient's physiological status
- Perceive odors that indicate unsafe environmental conditions

Movement
The applicant/student must be able to:

- Possess full manual dexterity of upper extremities, including neck and shoulders
- Possess unrestricted movement of lower extremities, back and hips

Lifting
The applicant/student must be able to:

- Lift and/or support at least 50 pounds to safely transfer, ambulate, and reposition patient

If an applicant/student should present with any limitation in the above areas, each case will be reviewed on an individual basis. If possible, reasonable accommodations will be made.

Applicant Name (please print): _____

1. The applicant must sign and date the "Clinical Agency Consent and Release" statement.
2. The applicant must sign and date the "Health Insurance Agreement" statement.
3. The application will not be processed if the form is incomplete.

Clinical Agency Consent and Release: (Select one option, sign and date)

____I hereby give my consent/permission to the ISU School of Nursing and its representatives to release my medical, immunization, TB screening, and criminal history information to any clinical agencies that require such information for course-related clinical placements during all the academic years I am enrolled as a nursing student.

_____I do not give my consent/permission to the ISU School of Nursing to release my medical, immunization, TB screening, and criminal history information to any clinical agencies that require such information for course-related clinical placements. I understand that if I decline permission to release information to clinical agencies, I may be limited in clinical experience options and thus, it may result in my not fulfilling the School of Nursing clinical requirements.

I hereby release and hold harmless the State of Idaho, Idaho State University, its employees and representatives from any liability as the result of releasing or not releasing my criminal history and/or medical information to any clinical agency for course-related clinical placements.

By signing below, I confirm that I have read and agree to the terms above.

Signature of Applicant: _____ **Date:** _____

Health Insurance Agreement: (Sign and date)

I verify that I am covered by health insurance. I agree to maintain health insurance coverage throughout the nursing program which includes, but is not limited to, payment for treatment and follow-up procedures, including exposure to blood-borne pathogens as well as other potentially infectious materials. I verify that proof of current health insurance showing I am covered is on file with the School of Nursing.

Signature of Applicant: _____ **Date:** _____

It is the ongoing responsibility of the applicant to inform the School of Nursing of any significant changes in his/her health status. Academic action, up to and including removal from the program, may be incurred if there has been misrepresentation of information in any manner (deliberate or otherwise) on this health care form.