LCCC NURSING PROGRAM PHYSICAL FORM
TO BE SUBMITTED AFTER ACCEPTANCE

TO BE COMPLETED BY APPLICANT

Name of Applicant____
(Print Name)

Date of Birth__________________________

Childhood diseases ____

Hospitalizations (why and when) ____________________________________

____

Have you ever had:	Yes	No
a) Heart problems	☐	☐
b) Rheumatic fever	☐	☐
c) Epilepsy or seizures	☐	☐
d) Tuberculosis	☐	☐
e) Hepatitis	☐	☐
f) Difficult breathing past moderate exertion	☐	☐
g) Asthma	☐	☐
h) High Blood Pressure	☐	☐
i) Fainting Spells	☐	☐
j) Allergy to drugs, foods, etc.	☐	☐
k) Diabetes	☐	☐
l) Hearing problems	☐	☐
m) Back problems that prevent lifting more than 40 pounds	☐	☐
n) Arthritis	☐	☐
o) Vision problems (Other than corrected by lenses)	☐	☐

Do you have any limitations that require accommodations to be successful in the program?

____

____

Are you currently receiving any medical treatment or taking any medications? ☐ Yes ☐ No

If so, please describe treatment and list medications __________________________

Have you ever been treated for any psychological issues? ☐ Yes ☐ No If yes, when ________

____

How would you describe your general state of health? __________________________

I have revealed my medical history truthfully and wholly. I authorize my medical provider to give information to the LCCC Nursing Department regarding my ability to participate in clinical rotations.

____________________________________ ______________________
Applicant's Signature Date

Once both pages are completed, please submit this form to: Nursing Program
Laramie County Community College
1400 E. College Drive
Cheyenne, WY 82007

HEALTH CARE PROVIDER TO COMPLETE THIS SIDE Student Name ____________

Please check Yes if the applicant's past or present medical history indicated any of the below. Explain if "Yes."

Yes	No	
☐	☐	Chronic Illness ____________
☐	☐	Physical disability ____________
☐	☐	Acute Illness ____________
☐	☐	Recurring Physical or Mental health concerns ____________
☐	☐	Visual Impairment ____________
☐	☐	Hearing Loss ____________
☐	☐	Neck, Shoulder, Back Problems ____________

Significant medical history of applicant ____________

____

REQUIRED IMMUNIZATIONS

1. 2-Step PPD (Mantoux) (within one year) Date ______ Reaction ______ Date ______ Reaction ______
   Chest x-ray if PPD is positive: Date ____________ Results ____________
2. Diphtheria-Tetanus Toxoid (TdaP) (within 10 years) Date ____________
3. Flu Vaccine (October-March) Date ____________
4. MMR – All students admitted to the nursing program are required to verify two doses of the MMR vaccine or have a positive titer drawn to show immunity. Having had the disease does not constitute immunity.
   Rubella Titre – Date ____________ Immune ☐ Yes ☐ No
   Rubeola Titre – Date ____________ Immune ☐ Yes ☐ No
   Mumps Titre – Date ____________ Immune ☐ Yes ☐ No
   MMR Titre – Date ____________ Immune ☐ Yes ☐ No
   OR 2 doses MMR vaccine – Date ____________ Date ____________
5. Varicella Titre – Date ____________ Immune ☐ Yes ☐ No
   OR 2 doses Varicella vaccine – Date ____________ Date ____________
   Note: Having had the disease does not constitute immunity.
6. Hepatitis B: Submit proof from health care provider that student is in the process of receiving vaccine.
   Dates: (1) ____________ (2) ____________ (3) ____________ Completed ____________
   Hepatitis B Titer – Date ____________ Immune ☐ Yes ☐ No Date ____________
7. Color Vision: Distinguishes all colors ☐ Yes ☐ No If not, what colors are involved? ____________
   (Color Vision Testing can be done in LCCC's nursing office.)
8. Applicant can perform essential functions of a nurse. ☐ Yes ☐ No

RECOMMENDATION: From the preceding exam, do you believe ____________ (Name) is capable to undertake all the demands placed on a health care provider?

Remarks ____________

____

____
Health Care Provider's Signature

PRINT Health Care Provider's Name ____________

Address ____________

Phone ____________ Date ____________