Division of Nursing
Mayowa Otuada DNP, APRN, WHNP-BC
Director of BSN Program
201 W. University Blvd.
Odessa, Texas 79764
Phone: 432-335-6408

Pre-Participation Student Physical Examination and Clearance

NAME: _____DOB: _____

Program

___ ADN ___ LVN Andrews ____LVN Monahans ____Radiologic Technology

____ Physical Therapist Assistant _____ EMT _____ BSN

Based on the assessment, examination, and evaluation, this student is capable of participating in classroom and clinical activities in the nursing or allied health program.

YES _____ NO _____

Healthcare Provider Printed Name/Credentials

Healthcare Provider Signature: _____Date: _____

Address: _____

Phone: _____

NAME: _____ DOB _____

ODESSA COLLEGE - NURSING AND ALLIED HEALTH
STUDENT PHYSICAL EXAMINATION

Physical Assessment to be completed by the examining health care provider:

Ht_____WT_____BMI_____T_____P_____R_____B/P_____

	N	A	
HEENT			
Neck/Thyroid			
Cardiovascular			
Respiratory			
Abdomen			
GU (Male)			
Neurologic			
Extremities			
Skin			

Medical Recommendations:

_____

Based on the medical/social history and physical assessment this student is physically capable of participating in classroom and clinical activities in the nursing or allied health program.

YES _____ NO _____

_____

Healthcare Provider Printed Name/Credentials

Healthcare Provider Signature: _____Date: _____

Complete Address: _____

NAME: _____ **DOB:** _____

ODESSA COLLEGE - NURSING AND ALLIED HEALTH
STUDENT MEDICAL/SOCIAL HISTORY

TO BE COMPLETED BY THE STUDENT PRIOR TO THE PHYSICAL EXAMINATION

ALLERGIES:

DO YOU HAVE NOW OR HAVE YOU EVER HAD:

	YES	NO	Comments:
1.HEARING PROBLEMS			
2.VISION PROBLEM			
3.ACCIDENT /TRAUMA			
4.PROSTHESIS			
5.CHICKEN POX			
6.SURGERY			
7.BLOOD TRANFUSION			
8.BLOOD DISORDER			
9.CANCER			
10.AUTOIMMUNE			
11.CHRONIC SKIN CONDITION			
12.MUSCULOSKELETAL SYSTEM PROBLEM			
13.HEPATIC SYSTEM			
14.CONGENITAL/PROBLEM CONDITION			
15.ASTHMA			
16.RESPIRATORY			
17.CHRONIC CONDITION			
18.HYPERLIPIDEMIA			
19.DIABETES			
20.THYROID			
21.SEIZURES			
22.HIV			
23.TUBERCULOSIS			
24.TOBACCO USE			
25.ALCOHOL USE			
26.PRESCRIPTION MEDICATIONS CURRENTLY TAKING			
27.DEPRESSION			
28.PSYCHIATRIC/MENTAL			

I certify all of the preceding information is accurate and complete to the best of my knowledge.

I understand that falsification of this document may constitute cause for dismissal from the nursing or allied health program.

I further understand that it is my responsibility to maintain current and accurate health information while enrolled in the nursing or allied health program at Odessa College.

Student Name-Please Print: _____

Student Signature: _____

Date: _____

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