INDIANA WESLEYAN UNIVERSITY

SCHOOL OF NURSING
Division of Pre-licensure

HEALTH CLEARANCE FORM

Name ..... **Date of Assessment**.....
Last First Middle

Date of Birth: .....

PPD/TB Test: Date & time given..... Date & time read ..... ……..Result ..... mm

Two MMR's #1 .....#2 ..... **Rubella IGGTitre *** ..... ……..Result .....

Hepatitis B Series: #1…… #2……..……#3……..…… **Tdap Vaccine** Date given ……..…….……

Two Varicella Vaccines: #1..... #2..... OR **Varicella IGG Titre*** .....Result .....

* ***COPY OF LAB RESULTS MUST BE ATTACHED***

EXAMINATION (to be completed by examining physician/nurse practitioner/physician assistant)

Height…… Weight..... Blood Pressure ..... Pulse

Is there any abnormality of the following? .... …… Comments: ……

Heart: Enlargement..... Murmur ..... Dyspnea ..... Edema .....

Eyes, ears, nose, mouth, pharynx .....

Vision: Left..... Right ..... Both..... With correction ☐ Without correction ☐

Nervous system (include gait, reflexes, paralysis) .....

Respiratory system ..... **Abdomen** .....

Genitourinary system ..... **Endocrine system** .....

Musculoskeletal system (include spine, joints, deformities, amputations) .....

Unless otherwise noted, this individual is able to participate in the clinical setting. (The Student Nurse role requires walking, bending, lifting, and standing for extended periods of time to manage, coordinate and administer nursing care including the ability to lift 50 pounds and push and pull 200 pounds.)

Notes:

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Signature Date

Printed name/credentials …….....

Address:.....

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