

Seattle Pacific University  
School of Health Sciences

**PHYSICAL ASSESSMENT FORM**

This information is required for admission to the nursing program. It must be completed by a physician, PA or nurse practitioner. This form must be completed in addition to the Medical History Record (self-reported) and Nursing Student Immunization Record. Documentation of TB testing is required. The dates of two TB test 1-3 weeks apart or yearly tests (two) are required and should be reported on the student immunization record. If previous positive PPD, documentation of CXR results, Symptom Check Sheet and INH or treatment required. **Please return the completed form to: Health Services, 1<sup>st</sup> Floor**

**Watson Hall. Or mail to:**

**Health Services**

**Seattle Pacific University**

**3307 Third Avenue West Suite 110**

**Seattle WA 98119-1922.**

Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

DOB \_\_\_\_\_

PMH \_\_\_\_\_

ROS \_\_\_\_\_

Blood pressure \_\_\_\_\_

Pulse \_\_\_\_\_

Weight \_\_\_\_\_

Height \_\_\_\_\_

Hearing \_\_\_\_\_

Vision R-Eye \_\_\_\_\_ L-Eye \_\_\_\_\_

**Describe any abnormalities in the following areas:**

Eyes \_\_\_\_\_

HEENT \_\_\_\_\_

Neck \_\_\_\_\_

Lymph nodes \_\_\_\_\_

Skin (scars, lesions) \_\_\_\_\_

Chest \_\_\_\_\_

Lungs \_\_\_\_\_

Breast \_\_\_\_\_

Cardiovascular \_\_\_\_\_

Abdomen \_\_\_\_\_

Musculoskeletal \_\_\_\_\_

Genitalia (hernia/testicular) \_\_\_\_\_

**Medications:** List all medications you are currently taking \_\_\_\_\_

**Drug Allergies:** \_\_\_\_\_

**Other Allergies:** \_\_\_\_\_

**See Reverse**

Required Labs:

CBC Normal  Abnormal   
UA Normal  Abnormal   
PAP Normal  Abnormal  Deferred per PAP guidelines

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TB TEST #1 Date given \_\_\_\_\_ Date read \_\_\_\_\_ mm induration

TB TEST #2 Date given \_\_\_\_\_ Date read \_\_\_\_\_ mm induration

**OR**

Date of positive TB test \_\_\_\_\_

CXR results \_\_\_\_\_ (Must be within 5 yrs and copy of report attached)

Copy of Public Health's Annual TB Symptom Check Sheet must also be submitted.

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**Color Blindness Exam** (Pseudo Isochromatic Plates for Testing Color Perception)

List name if other test used \_\_\_\_\_ Normal?  Yes  No

**The American Disability Act (ADA):**

Identified Disability \_\_\_\_\_

Accommodation \_\_\_\_\_

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**Examiner's Summary:**

Based upon this assessment, it is my judgment that \_\_\_\_\_ (*student name*) is able to perform the duties required of a nursing student.

\_\_\_\_\_  
*Examiner's Signature*

\_\_\_\_\_  
*Date*

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**Release of Information:**

I understand that this authorization permits the Health Center at Seattle Pacific University to release information contained in this physical and all immunization records to the School of Health Sciences at Seattle Pacific University. Immunization information contained in Washington State's Child Profile and color blindness test may also be released to agencies prior to student placement.

- ❖ Dates of immunizations required for entry
- ❖ Current medical condition at date of entry into Health Sciences Nursing Program
- ❖ Current medication list
- ❖ Disability conditions requiring accommodations
- ❖ Color blindness status

\_\_\_\_\_  
*Signature of Student*

\_\_\_\_\_  
*Date*