LAMAR UNIVERSITY
COLLEGE OF ARTS AND SCIENCES
JOANNE GAY DISHMAN SCHOOL OF NURSING
PRACTICUM READINESS DOCUMENTS

Part III: Physical Examination

NAME _____ **L#** _____ **DOB** _____

Students in the Lamar University Nursing Program must be in a state of health that will allow them to participate in all practicum phases of the program of study in a manner that will not jeopardize the health or safety of clients or themselves. The following items are to assist in determining this requirement.

INSTRUCTIONS:

- Have Health Care Provider complete this form. Only this form or the Physical Exam completed at the Lamar University Student Health Center will be accepted.
- Submit completed form by emailing it to lamar@sentrymd.com **–or– upload** it directly to the Sentry MD Secure Uploader as a PDF attachment (go to https://upload.sentrymd.com/)
- Retain a copy of the completed form for your files

If the results are outside normal limits the student will be counseled by the program director regarding any implications that the results may have for completion of program requirements.

VISION:

RIGHT vision (corrected) _____ LEFT vision (corrected) _____

HEARING:

Hearing Deficit RIGHT: ☐ No ☐ Yes Hearing Deficit LEFT: ☐ No ☐ Yes

LIFTING:

Ability to lift 50 pounds and turn heavy objects: Unlimited? : ☐ No ☐ Yes
If no, provide written documentation from Primary Care Physician of limitations.

LIMITATIONS:

Are there any practicum situations, because of mental or physical limitations, this individual should not be assigned to: ☐ No ☐ Yes If yes, please explain_____

_____

CHRONIC CONDITIONS:

Does this individual have any chronic health problems: ☐ No ☐ Yes If yes, please explain_

_____

If yes, are these problems under appropriate medical supervision?_____

Please indicate any specific health conditions that faculty in the nursing program need to be aware of. ☐ None ☐ Condition: _____

Please explain: _____

Signature: _____ Date: _____

Printed Name:_____ Title: _____

Phone Number: _____

Name of Clinic: _____

Address: _____

City, State, ZIP: _____

Place Provider's Stamp Here