KISHWAUKEE COLLEGE
Health & Education Division

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Fax: 815-825-2923
www.kish.edu

PRE-ENTRANCE MEDICAL RECORD

INSTRUCTIONS: Student should alert the program Director or Coordinator at Kishwaukee College if your healthcare provider does not give you consent to perform without restrictions.

THIS SECTION TO BE COMPLETED BY STUDENT:

Student's Name: _____ DOB: _____

Student's Address: _____
Street City State Zip

INDICATE WHICH PROGRAM THIS FORM IS BEING COMPLETED FOR:

- ☐ EMS
- ☐ RN – Nursing
- ☐ Radiologic Technology
- ☐ Therapeutic Massage
- ☐ Other _____

THE REMAINING SECTIONS TO BE COMPLETED BY LICENSED PHYSICIAN OR CERTIFIED NURSE PRACTITIONER:

DATE OF EXAM:		**HEIGHT:** **WEIGHT:**
BLOOD PRESSURE:		**PULSE:**
	NORMAL	**PLEASE EXPLAIN ANY ABNORMALITY**
EARS		
EYES (Snellen)	OD OS OU	
NOSE		
TEETH/MOUTH		
THROAT/NECK		
LUNGS		

(over)

HEART		
MUSCULOSKELETAL		
NEUROLOGICAL		
ABDOMEN (e.g., Hernia)		
HAS THIS PATIENT HAD CHICKEN POX?		
ALLERGIES:		
MEDICATIONS: List prescribed medications for this person, and identify if it would impair or affect clinical performance:		

Has this person ever been diagnosed/treated or is currently being treated for any of the following?

MENTAL DISORDERS:
EMOTIONAL INSTABILITY:
CHRONIC ILLNESS (e.g., Heart Disease, Diabetes, Hypertension, Orthopedic Problems, Seizure Disorders, Allergies, Asthma, Recurrent Headaches, etc.):
ALCOHOL OR OTHER SUBSTANCE ABUSE:
PHYSICAL IMPAIRMENTS:

- **Can this person function as a student in the Academic Program indicated without posing a "direct threat" to the health and/or safety of the person or others? ☐ yes ☐ no**
- **Can this person perform in both theory and clinical practice areas in the Academic Program indicated without any restrictions? ☐ yes ☐ no**

If no, please explain:

Physician's Signature: _____ Date: _____

Physician's Name (Print): _____ Physician's Phone: _____

Physician's Address: _____