Western Carolina University | School of Nursing

Student Health Examination Form

Once fully completed, upload form into your CastleBranch Account

Program of Enrollment (check one):

☐ BSN ☐ ABSN ☐ RN-PC ☐ FNP ☐ NL ☐ NEd ☐ CRNA ☐ DNP

Questions: Student Services - School of Nursing, wcunursing@wcu.edu

Student Name: _____ Student ID: _____ DOB: _____

Phone Number: _____ Email: _____

Student Signature: _____ DATE: _____

You will not be permitted to enter any clinical agency as a nursing student providing care to the public until this form is complete and in your department file.

This document is in addition to and does not substitute for the WCU Health Services form for students enrolled in *residential* programs. This document is considered current as long as the student is continuously enrolled in their program. If there is a change in a student's health status while in the program, the student must submit an updated health form or note from a health care provider stating that the student is physically and/or mentally able to continue with school activities as specified in the Core Competencies. Please see additional information that the Office of Accessibility Resources provides if you will be in need of these resources while enrolled in your program.

Health Examination

To the physician, nurse practitioner, or physician's assistant:

Please perform a complete health history and physical/emotional evaluation. Keep whatever records of your findings that are appropriate to your practice; these records should be available to the student later on request. The physical must be within 18 months prior to starting the above program. Summarize your findings below, using additional pages as necessary:

I examined this student, _____, on ____/_____/_____ and found her/him to be in good physical and emotional health, able to provide safe nursing care to the public.

OR

I examined this student, _____, on _____ and found the following physical or emotional conditions that might interfere with her/his ability to provide safe nursing care to the public:

The following suggested therapies or devices may compensate for these conditions:

Signature/title: _____ Date: ____/_____/_____
(*Healthcare Provider)*

Clinic Name: _____

Clinic Address: _____