TARRANT COUNTY COLLEGE
NURSING HEALTH CERTIFICATE

Name:_____ Student ID#:_____
Age:_____ Sex: _____Date of Birth: _____
Address:_____ Cell Phone #:_____
City:_____ State:_____ Zip Code:_____
Email Address:_____
Emergency Contact:_____ Daytime Phone #:_____

HEALTH HISTORY

(To be completed by student)

Check conditions, which are applicable:
Personal:

( ) Diabetes	( ) Kidney Disease	( ) Pregnancy	( ) Chemical Dependency
( ) Epilepsy	( ) Asthma	( ) Heart Disease	( ) Sexually Transmitted Disease
( ) Ulcer	( ) Hepatitis	( ) High Blood Pressure	( ) Thyroid Condition
( ) Tuberculosis	( ) Rheumatic Fever	( ) Frequent Headaches	( ) Arthritis or Rheumatism
( ) Cancer	( ) Sinus Infection	( ) Anemia	( ) Excessive Bleeding on injury
( ) Back Problems	( ) Learning Disability	( ) Vision or Hearing Problems	

( ) Mental Illness-Explain Below (or on back of page)_____

Allergies:_____
Regular Medications:_____
_____
Provide dates, diagnosis and treatment (if any) for any health problems you have had during the past five years:_____
_____
_____
Accomplishing the objectives of the nursing program requires lifting and moving patients, corrected vision, hearing adequate for blood measure measurement and physical stamina. Do you have any physical limitations that would restrict such activities?_____Yes_____No
If YES, explain
restreictions_____
_____
_____
Students are responsible for their own health insurance coverage, and it is required by some clinical facilities. Do you have health insurance?_____Yes_____No

Additional Comments:_____
_____
_____
Student Signature:_____
Printed Name:_____
Date:_____

PHYSICAL EXAMINATION
TO BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROVIDER

Description of physical and mental health status:_____
_____
_____
_____
_____
_____

Current health problems:_____
_____
_____
_____
_____
_____

Does this student have any physical/emotional limitations that would restrict the delivery of direct patient care in the hospital setting? _____Yes _____No If YES, please explain restrictions:_____
_____
_____
_____
_____
_____

Additional Comments:_____
_____
_____
_____

Physician or Health Care Provider
Physicians Name:_____
Address:_____
Phone #:_____

Physician's Signature:_____
Date:_____