YOLLE INSTITUTE

Medical History & Physical Examination Form

LPN Program — to be completed by the student and healthcare provider prior to clinical placement.

Please print clearly and mark all applicable boxes with an X.

Student Name _____ DOB _____ MM/DD/YYYY

Program: LPN

Health History (Student)

Please indicate whether you have or have had any of the following conditions.

Heart disease:	☐ Yes	☐ No
Hypertension:	☐ Yes	☐ No
Diabetes:	☐ Yes	☐ No
Asthma:	☐ Yes	☐ No
Seizure disorder:	☐ Yes	☐ No
Kidney disease:	☐ Yes	☐ No
Liver disease:	☐ Yes	☐ No
Mental health condition:	☐ Yes	☐ No
Back/neck problems:	☐ Yes	☐ No
Vision impairment:	☐ Yes	☐ No
Hearing impairment:	☐ Yes	☐ No
Other chronic illness:	☐ Yes	☐ No

Surgeries _____

Hospitalizations _____

Allergies _____

Current Medications

1. _____ 2. _____ 3. _____

Medical History & Physical Examination Form (LPN) (continued)

Physical Examination (Provider)

Height _____ Weight _____ BMI _____

Blood Pressure _____ Pulse _____ Respirations _____

Temperature _____ Vision _____ Hearing _____

Provider Assessment

Medical clearance:

- ☐ Cleared without restrictions
- ☐ Cleared with restrictions: _____
- ☐ Not cleared

Healthcare Provider Certification

I certify that I have examined the above-named student and, to the best of my professional knowledge, the information provided on this form is accurate.

Provider Name _____ Credential (MD / DO / APRN / PA) _____

Practice _____ License # _____

Signature _____ Date _____ MM/DD/YYYY