APPLICATION PROCEDURE

Complete the enclosed forms and return them along with other required information to the Department of Nursing. Completed applications, as noted below, received by June 1st will receive priority placement.

1. **Application for Baccalaureate Nursing Program**: Please complete the application (attached) carefully, filling in all areas. Submit with the other application materials. The application serves as the formal application to the nursing major.

2. **Transcripts from Post-Secondary Education**: Official transcripts from all post-secondary education institutions attended should be sent to the Presentation College Admissions Office. It is the applicant’s responsibility to ensure that all necessary, official transcripts are sent and received at Presentation College.

3. **References**: Two complete Reference Request forms are required to accompany the other application materials. The forms are included in this packet. At least one of the two references must be from an individual who can directly speak to the student’s academic ability. The other may be from an employer or person who can provide data on the student’s personal characteristics. (Family members/friends are not appropriate references.)
   - Please complete the Waiver of Rights to Review Statement on each reference form.
   - Send a Reference Request to each individual who shall serve as a reference. Indicate that the form is to be returned to the student in a sealed envelope before a specified date. Please place the appropriate return address in the space at the bottom of the form.

4. **Current Immunizations and Health Form**: Students are required to submit documentation of all immunizations and health form to the Nursing Department prior to August 1st. Students cannot begin nursing classes unless their immunization history is up-to-date and on file in the Nursing Department. It is the student’s responsibility to maintain current immunization status.

   THE APPLICATION IS CONSIDERED COMPLETE ONLY WHEN THE ENTIRE APPLICATION IS SUBMITTED INCLUDING:
   - APPLICATION (SECTION I: PERSONAL STUDENT INFORMATION AND ESSAY, SECTION II: BACKGROUND INFORMATION)
   - TRANSCRIPTS
   - TWO REFERENCES
   - A COPY OF CPR CERTIFICATE

   NO STUDENT CAN BE CONSIDERED FOR FULL ACCEPTANCE INTO THE MAJOR UNTIL ALL OF THE ABOVE ARE RECEIVED.

Following Acceptance to the Nursing Major:

5. **Background Check**: Presentation College nursing students accepted into the nursing program will be required to submit a national background study. Information on submitting the background studies will be enclosed with acceptance letters.
   - **Fairmont Students Only**: Minnesota state law requires an additional state background checks on any person who directly works with patients or residents in health care facilities. Presentation College nursing students accepted into the nursing program will be required to submit a state and federal background study. Information on submitting the background studies will be enclosed with acceptance letters. The Background Study Clearance must indicate that the student can provide direct contact services. The student cost for the background check(s) varies from $50 to over $200, depending on if they have lived outside of the United States or not. Release forms and the results of the background study are valid for one year only.

RETURN COMPLETED APPLICATION FORMS TO:

**Aberdeen Students** - Presentation College, Dept. of Nursing, 1500 North Main Street, Aberdeen, SD. 57401
   Phone - (605) 229-8472

**Fairmont Students** - Presentation College, Dept. of Nursing, 115 South Park, Suite 105, Fairmont, MN. 56031
   Phone – (507) 235-4658
Baccalaureate Nursing Program
Student Checklist

Use this checklist to keep track of the various parts of the application process.

Date Submitted: ____/____/____

☐ Application for Baccalaureate Nursing Program

☐ Transcripts—official transcripts from all post-secondary education credits must be provided to the Presentation College Admissions Office prior to submission of the Nursing Program application.

☐ Reference from:
  1. ___________________________ → Cover Letter and Form sent: ____
      → Reference Form received: ____
  2. ___________________________ → Cover Letter and Form sent: ____
      → Reference Form received: ____

☐ Photocopy of Immunizations upon Acceptance

☐ Completed Heath Form upon Acceptance

☐ COPY ALL APPLICATION MATERIALS YOU ARE SUBMITTING.
   You may need to refer to it during the application process.

IT IS THE STUDENT’S RESPONSIBILITY TO BE CERTAIN ALL MATERIALS ARE SUBMITTED TOGETHER AND RECEIVED BY THE DUE DATE.

FINAL ACCEPTANCE INTO THE MAJOR WILL BE CONTINGENT ON COMPLETION OF CRIMINAL BACKGROUND STUDIES. MORE INFORMATION ABOUT THESE WILL BE INCLUDED IN ACCEPTANCE LETTERS.
Application for Admission

Please print neatly and legibly in ink                      Date Submitted: ___/___/____

SECTION 1: PERSONAL STUDENT INFORMATION

Name ____________________________________________________________

Last                First                M.I.          /Previous

Email Address: ____________________________ Date of Birth: ________________

Permanent Address: ______________________________________________

Street                City                State                Zip

Local Address: __________________________________________________

Street                City                State                Zip

Home Phone #: (____)_____________   Cell Phone #: (____)_____________

Person to be notified in case of emergency:

Name ____________________________________________________________

Last                First                Relationship

Home Address: __________________________________________________

Street                City                State                Zip

High School Education:

____________________________________________________________________________

Name of High School    Location    Dates of Attendance    Graduation Date

Post-Secondary Education: List all institutions you’ve attended, beginning with the most recent.

____________________________________________________________________________

Name of Institution    Degree Obtained    Year Completed

____________________________________________________________________________

Name of Institution    Degree Obtained    Year Completed

If you have attended or have been admitted to another program of nursing, please list program.

____________________________________________________________________________

Name of Program    Address of Program    Reason for Leaving

Membership Organizations: Specify offices held, committee work, projects, etc.

____________________________________________________________________________

Name of Organization    Relevant Details    Start Date    End Date

____________________________________________________________________________

Name of Organization    Relevant Details    Start Date    End Date
SECTION 1 CONTINUED: STUDENT INFORMATION

Have you ever worked in a health care position? If yes, please describe.

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Other experiences and information that you believe would be relevant for consideration of your application: Examples may include, but are not limited to; community projects, student-exchange programs, mission trips, volunteering, etc.

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Essays: Please provide 300-400 word responses to the following questions. Your essay responses must be typed and double-spaced, and each essay must be on a separate piece of paper.

1. You will be a student in a very competitive program. Describe why you believe you will be a successful student in this nursing program, including specific strengths and weaknesses you possess.
2. Discuss one health care issue and what led to your knowledge and interest in this area.
3. Describe some of your experiences that you believe will contribute to your success within the nursing profession, including life experiences, work experiences and community involvement.

Your essay responses should exemplify your best writing ability. Criteria used for rating the essays will include the following:

• Clear expression of thought
• Grammar/sentence structure, spelling, and professional overall appearance
• Thorough discussion of essay topics

I affirm that all information supplied on this application is correct. I have reviewed the admission requirements listed and affirm that I am qualified to apply. I understand that my admission will not be complete until I have submitted all necessary credentials. I further understand that withholding requested information or giving false information may make me ineligible for admission or enrollment.

Signature: _______________________________ Date: _______________________________

NOTICE OF NONDISCRIMINATION

Presentation College is committed to a policy of nondiscrimination on the basis of race, color, gender, age, national origin, disability, marital or veteran status, or religion, in admission, educational programs or activities, and employment, all as required by applicable laws and regulations. Responsibility for coordination of compliance efforts and receipt of inquiries, including those concerning Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, has been delegated to the Director of Human Resources, 605-229-8504, and the Americans With Disabilities Act (ADA) to the Office of Disability Services, 605-229-8580, Presentation College, 1500 North Main Street, Aberdeen, SD 57401.

Presentation College is an Equal Opportunity and Affirmative Action Employer.
**SECTION II: BACKGROUND INFORMATION**

Your responses to questions 1-10 are necessary to meet agency regulations for the public safety and to be in compliance with Minnesota Board of Nursing Licensure requirements.

Please provide an explanation below for every YES answer.

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>
| 1. Have you ever violated a state or federal law relating to the practice of nursing? | ☐   | ☐
| 2. Have you ever violated a state or federal law or rule relating to narcotics or controlled substances, or other similar regulations? | ☐   | ☐
| 3. Have you ever been convicted, entered a plea of guilty, nolo contendere, or no contest, for any felony, gross misdemeanor or misdemeanor offence? | ☐   | ☐
| 4. In the last five years, have you ever misused or abused alcohol, other drugs or chemicals or been considered chemically dependent? | ☐   | ☐
| 5. In the last five years, have you been fired from a nursing-related job? | ☐   | ☐
| 6. Are you under investigation or are you the subject of any pending or past disciplinary action by a nurse licensing agency or have you been refused a nursing license by a state or country? | ☐   | ☐
| 7. Do you have a physical or mental disability, illness or disease (such as visual or auditory impairments, mobility impairments, mental or physical conditions, and learning disabilities) that may impair your ability to practice nursing or be potentially harmful to the public? If yes, please attach a statement explaining how this has been resolved or managed to allow you to safely practice nursing. | ☐   | ☐
| 8. Have you ever received notification from the Minnesota Department of Human Services or the United States Department of Health and Human Services, Office of the Inspector General that you have been disqualified from providing direct care or excluded from participation in Medicare or Medicaid? | ☐   | ☐
| 9. Have you ever been suspended from any college or university? If the answer is yes to this question, please complete a release of information form (available in the Nursing Department office) and submit it with your application packet. | ☐   | ☐
| 10. Have you ever been denied admission to another nursing program? | ☐   | ☐

Name of program: ____________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Signature: _____________________________ Date: __________________________
Reference Request

Send this reference request to each individual who will serve as a reference. The form is to be returned to the student in a sealed envelope with signature across the seal.

**WAIVER OF RIGHT TO REVIEW STATEMENT**

I, ________________________________, *waive / do not waive (please circle only one) the right to access confidential material submitted by reference.

Signature of applicant: ________________________________

Date: ________________________________

*Waive = student **may not** review reference  *Do not waive = student **may** review copy of reference after application process is complete

All completed forms will be treated confidentially should the student sign the Waiver of Right to Review Statement above.

I, ________________________________, am requesting that you serve as a reference for my application to begin the Baccalaureate Nursing Program at Presentation College. To assist in evaluating my application, please complete this form and return it to me in a sealed envelope (with your signature over the seal).

**DIRECTIONS:** In completing the form, please rate the applicant in comparison to other students and/or employees you have known.

<table>
<thead>
<tr>
<th></th>
<th>Exceptional</th>
<th>Above Average</th>
<th>Average</th>
<th>Below Average</th>
<th>No Information</th>
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<tbody>
<tr>
<td>Intellectual ability</td>
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<tr>
<td>Caring attitude</td>
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<td>Leadership ability</td>
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<td>Motivation to work</td>
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<td>Ability to work with others</td>
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<td>Ability to express self verbally</td>
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<td>Writing ability</td>
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<td>Emotional maturity</td>
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<td>Likelihood of career success</td>
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<td>Problem solving ability</td>
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<tr>
<td>Analytic ability</td>
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</tbody>
</table>

How long and under what circumstances have you known the applicant?
What limitations do you see that this individual may have in completing the Baccalaureate Nursing Program?

How does this individual handle stressful situations?

Please make any comments you think would assist faculty members in evaluating this candidate.

Thank you.

Signature of reference: ____________________________________________

Name (please print): ______________________________________________

Title: ____________________________________________________________

Address: __________________________________________________________

_______________________________________________________________

Date: ____________________

Please return form to applicant in a sealed envelope (signature across seal) by: __________________

(Applicant – enter date)

Applicant address: ________________________________________________

_______________________________________________________________

_______________________________________________________________

STUDENT: PLEASE SUBMIT BOTH OF YOUR SEALED REFERENCE FORMS WITH YOUR APPLICATION
Reference Request

Send this reference request to each individual who will serve as a reference. The form is to be returned to the student in a sealed envelope with signature across the seal.

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<td>Signature of applicant: ________________________________</td>
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<td>Leadership ability</td>
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<td>Motivation to work</td>
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What limitations do you see that this individual may have in completing the Baccalaureate Nursing Program?

How does this individual handle stressful situations?

Please make any comments you think would assist faculty members in evaluating this candidate.

Thank you.

Signature of reference: __________________________________________________________

Name (please print): ____________________________________________________________

Title: ________________________________________________________________

Address: _________________________________________________________________

________________________________________________________

Date: ______________________

Please return form to applicant in a sealed envelope (signature across seal) by:  ________________ (Student – enter date)

Applicant address: ________________________________

________________________________________________________

________________________________________________________

________________________________________________________

STUDENT: PLEASE SUBMIT BOTH OF YOUR SEALED REFERENCE FORMS WITH YOUR APPLICATION
PART I: IMMUNIZATION RECORD

To be completed and verified by a healthcare provider or public health official before completing the required Report of Medical History (Part II) and Report of Health Evaluation (Part III). Documentation for antibody tests/titers must be attached.

1. TETANUS, Diphtheria, Pertussis (Tdap) (Within 10 years) __________ Month/Day/Year

2. POLIO SERIES of at least 4 doses
   (1st) __________ or primary series of 3 doses
   (2nd) __________ (for individuals over 18 years of age) or Positive Polio titer attached
   (3rd) __________
   (4th) __________ Month/Day/Year

3. MEASLES/MUMPS/RUBELLA - 2 doses
   (1st) __________ or Positive Measles, Mumps, and Rubella titers attached
   (2nd) __________ Month/Day/Year

4. Hepatitis B - series of 3 to be completed by one year after first enrolling at Presentation College
   (1st) __________ or Positive hepatitis B surface antibody titer attached
   (2nd) __________
   (3rd) __________ Month/Day/Year

5. TB (MANTOUX) test
   STEP 1
   Date administered __________
   Date read __________
   Results (in mm) __________
   Read by __________

   STEP 2
   __________ or If history or positive skin test:
   Date of conversion __________
   Date of most recent chest x-ray (documentation must be attached) __________

   INH or other drug therapy start date __________ end date __________

   Where were you treated? __________

   Are you experiencing any of the following?
   Recent weight loss yes ___ no ___
   Night sweats yes ___ no ___
   Persistent cough yes ___ no ___

   NOTE:
   1) All students must begin with a two-step skin test (two separate TB tests placed 1-3 weeks apart, and receive regular 5-step skin tests within every 12 months thereafter.
   2) A TB Quantiferon blood test is accepted in place of a two-step skin test and must be completed within every 12 months thereafter.
   3) Mantoux testing is contraindicated for individuals with a prior positive skin test.
   4) Previous vaccination with BCG is not a contraindication to Mantoux testing. Previously vaccinated individuals with significant reactions to a TB skin test should be evaluated for the presence of disease and managed accordingly.

6. Influenza Immunization
   Date __________

7. Chicken Pox or herpes zoster: History of disease verified by physician, or positive titer attached, or 2 immunizations:
   date of disease __________ or Immunizations: date __________ date __________

Health care provider or public health official verifying above immunizations:

PRINTED NAME: ___________________ PROVIDER SIGNATURE: ___________________

DATE: __________ ADDRESS: ___________________ TELEPHONE: __________

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PRESENTATION COLLEGE
PART II: REPORT OF MEDICAL HISTORY
PLEASE COMPLETE THIS BEFORE GOING TO YOUR HEALTH CARE PROVIDER FOR EXAMINATION

<table>
<thead>
<tr>
<th>LAST NAME (Print)</th>
<th>FIRST NAME</th>
<th>MIDDLE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>HOME ADDRESS (Number and Street)</th>
<th>CITY OR TOWN</th>
<th>STATE</th>
<th>ZIP CODE</th>
<th>DATE OF BIRTH</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN</th>
<th>HOME TELEPHONE NUMBER</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NEXT OF KIN'S BUSINESS ADDRESS</th>
<th>BUSINESS NUMBER</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>LIST OF COLLEGES YOU HAVE ATTENDED, ADDRESSES, AND DATES</th>
<th>CITIZENSHIP</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>ARE YOU A VETERAN? BRANCH AND LENGTH OF SERVICE</th>
<th>MARITAL STATUS</th>
<th>MAJOR/CLASS YOU ARE ENTERING</th>
</tr>
</thead>
</table>

FAMILY HISTORY

<table>
<thead>
<tr>
<th>Age</th>
<th>State of Health</th>
<th>Occupation</th>
<th>Age of Death</th>
<th>Cause of Death</th>
<th>Relative Relationship</th>
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<tbody>
<tr>
<td>Father</td>
<td></td>
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<tr>
<td>Mother</td>
<td></td>
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<tr>
<td>Brothers</td>
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<td></td>
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<tr>
<td>Sisters</td>
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</table>

Have any of your relatives ever had any of the following?

- Tuberculosis
- Diabetes
- Kidney Disease
- Heart Disease
- Arthritis
- Stomach Disease
- Asthma, Hay Fever
- Epilepsy, Convulsions
- High Blood Pressure

PERSONAL HISTORY. PLEASE ANSWER ALL QUESTIONS. Comment on all positive answers in space below or on additional sheet.

<table>
<thead>
<tr>
<th>HAVE YOU HAD?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scarlet Fever</td>
<td></td>
<td></td>
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<tr>
<td>Measles</td>
<td></td>
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<tr>
<td>German Measles</td>
<td></td>
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<tr>
<td>Mumps</td>
<td></td>
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<tr>
<td>Chicken Pox</td>
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<tr>
<td>Malaria</td>
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<tr>
<td>Tooth Trouble</td>
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<td></td>
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<tr>
<td>Sinusitis</td>
<td></td>
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<tr>
<td>Eye Trouble</td>
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<tr>
<td>Ear, Nose, Throat Trouble</td>
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<tr>
<td>Surgery</td>
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<tr>
<td>Appendectomy</td>
<td></td>
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<tr>
<td>Tonsillitis</td>
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<tr>
<td>Hernia Repair</td>
<td></td>
<td></td>
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<tr>
<td>Back</td>
<td></td>
<td></td>
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<tr>
<td>Other (specify)</td>
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<table>
<thead>
<tr>
<th>Insomnia</th>
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<th>No</th>
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<tbody>
<tr>
<td>Frequent Anxiety</td>
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<tr>
<td>Frequent Depression</td>
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<td></td>
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<tr>
<td>Worry or Nervousness</td>
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<tr>
<td>Recurrent Headache</td>
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<tr>
<td>Recurrent Colds</td>
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<td></td>
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<tr>
<td>Hay Fever, Asthma</td>
<td></td>
<td></td>
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<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
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<tr>
<td>Shortness of Breath</td>
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<td></td>
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<tr>
<td>Allergy</td>
<td></td>
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<tr>
<td>Pencillin</td>
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<tr>
<td>Penicillin</td>
<td></td>
<td></td>
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<tr>
<td>Sulfonamides</td>
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<td></td>
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<tr>
<td>Serum</td>
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<tr>
<td>Foods (which)</td>
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<tr>
<td>Latex</td>
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<tr>
<td>Other</td>
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<table>
<thead>
<tr>
<th>Heart Pressure in Chest</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Chronic Cough</td>
<td></td>
<td></td>
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<tr>
<td>Pelvic Pressure (Heart)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High or Low Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatic Fever or Rheumatoid Arthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease or Injury of Joint</td>
<td></td>
<td></td>
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<tr>
<td>Trig. Knee, Shoulder, etc.</td>
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<td></td>
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<tr>
<td>Back Problem</td>
<td></td>
<td></td>
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<tr>
<td>Tumor, Cancer, Cyst</td>
<td></td>
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<tr>
<td>Ulcer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach or Intestinal Trouble</td>
<td></td>
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<tr>
<td>Gallbladder Trouble or Calculus</td>
<td></td>
<td></td>
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<tr>
<td>Recurrent Diarrhea</td>
<td></td>
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</tr>
</tbody>
</table>

A. Has your physical activity been restricted during the past five years? (Give reasons and durations)
B. Have you had difficulty with school, studies, or teachers? (Give details)
C. Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? (Give details)
D. Have you had any illness or injury or been hospitalized other than already noted? (Give details)
E. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years? (Other than routine checkups?)
F. Have you been rejected for or discharged from military service because of physical, emotional, or other reasons? (If so, give reasons)

G. Do you intend to participate in sports while attending Presentation College? If so, provide details.
H. Do you exercise regularly? If so, provide details.
I. Do you have any questions in regard to your health, family history, or other matters, which you would like to discuss?

REMARKS OR ADDITIONAL INFORMATION (Use additional sheet if necessary)

Student’s Signature

Health Care Provider Signature (Acknowledging Review) Date

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PART III: REPORT OF HEALTH EVALUATION

TO THE EXAMINING HEALTH-CARE PROVIDER: Please review the student’s history and complete the physician’s form. Please comment on all positive answers. THIS STUDENT HAS BEEN ACCEPTED. The information supplied will not affect his/her status. It will be used only as a background for providing health care, if this is necessary. This information is strictly for the use of Presentation College and will not be released without student consent.

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MIDDLE</th>
<th>SEX:</th>
<th>M ☐</th>
<th>F ☐</th>
</tr>
</thead>
</table>

**HEARING**
Whisper test (softly whispered word @ 30-60 cm) R _______ L _______

**BP**
R _______ L _______

**Height** inches  Weight ____ lbs.

**Corrected Vision**

**BMI**

Are immunizations current?

**Right 20/**

**Left 20/*

**URINALYSIS (dipstick):**
Sugar
Albumin
Micro.

**HEMOGLOBIN or HEMATOCRIT (if indicated)**
__________ gms./%

Are these areas within normal limits? If not, describe fully. Use additional sheet if needed.

| 1. Head, Ears, Nose, or Throat | Yes | No |
| 2. Respiratory | | |
| 3. Cardiovascular | | |
| 4. Gastrointestinal | | |
| 5. Hernia | | |
| 6. Eyes | | |
| 7. Genitourinary | | |
| 8. Musculoskeletal | | |
| 9. Metabolic/Endocrine | | |
| 10. Neuropsychiatric | | |
| 11. Skin | | |

Comments:

Is the patient now under treatment for any medical or emotional condition? Yes _____ No _____

Is there any other body system impairment not previously noted? Yes _____ No _____

Comment or summary on overall health status:

**RECOMMENDATIONS:**
Student is physically able to assume classroom and/or clinical responsibilities. Yes _____ No _____ Explain:

Student is physically able to assume classroom and/or clinical responsibilities with the following restrictions:

Student is NOT able to assume classroom and/or clinical responsibilities for the following reason(s):

Recommendations for physical activity (PE, Intramurals, ROTC) Unlimited _____ Limited ____ Explain:

Do you have any other recommendations regarding the care of this student? Yes _____ No _____ Explain:

---

**PROVIDER NAME**

**PROVIDER SIGNATURE**

**ADDRESS**

**TELEPHONE**

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Return all information to:

PRESENTATION COLLEGE
DEPARTMENT OF NURSING
115 S PARK STREET SUITE 105
FAIRMONT, MN 56031

The recommended form has been approved by the Liaison Committee of the American College Health Association and the American Medical Association and approved by the American College Health Association. (Revised 3/86)