STUDENT: UPLOAD THIS FORM TO YOUR CASTLEBRANCH ACCOUNT

South Dakota State University
College of Nursing

Certificate of Health

Directions for the student

Please have this form completed by a licenses health care provider of your choice (i.e., nurse practitioners, physician assistant, or physician). If you have had a physical in the past year, your health care provider may use that information to make their recommendation. The Certificate of Health Form must be signed by the person completing the physical exam.

Name of student: _____

Date physical exam performed: _____

Health care providers recommendation

Students must possess certain functional abilities in order to complete requirements for the nursing clinical course. These abilities include: a) functional use of all senses; b) ability to perceive pain, pressure, temperature, position, equilibrium, and movement; c) functional use of gross and fine motor skills to carry out assessment and care delivery, such as lifting turning, transferring, treatments and administration of medications; d) ability to interact in a behaviorally appropriate manner. From the results of the history and physical examination it is indicated that there are:

____ No health concerns
____ Health concerns with possible clinical implications (list): _____
_____
_____

Final evaluation deferred at this time for the following reason: _____
_____

Comments: _____
_____
_____

Printed name of examiner: _____ Date: _____

Address: _____
_____

Phone Number: _____

(Signature of examiner) _____

Nursing student statement of continued health responsibility and release of information

If there is a change in my health status, I understand a subsequent health examination may be required by the College of Nursing Administration. I understand that it is my responsibility throughout the program to inform my clinical instructor(s) or the Department Head, Undergraduate Nursing of any condition that could possibly affect my performance or the welfare of my patients in the clinical area. I understand that this is necessary so arrangements can be made in my nursing courses. I understand that this disclosure is necessary to protect my health and well-being, as well as the health and well-being of clients for whom I may provide care. I authorize the release of information on this form to Nursing Student Services, College of Nursing to share, as appropriate, with my nursing clinical instructors and/or Department Head.

Student Signature: _____ Date: _____

This Certificate of Health is to be submitted to CastleBranch by the student. Do no upload physical exam information.