LEWISTOWN HOSPITAL SCHOOL of NURSING

GEISINGER-LEWISTOWN HOSPITAL
SCHOOL OF NURSING

Name _____

(To be completed by Health Care Provider)

GENERAL INFORMATION

Height _____ Pulse _____ Respiratory Rate _____

Weight _____ Blood Pressure _____

ALLERGIES: _____

_____

VISION: Corrective Lenses: Yes ☐ No ☐

Acuity	Right	Left	Both
Horizontal Field	Right	Left	Both
Depth Perception	Right	Left	Both
Color	Pass	Fail	

	WNL	If no, explain
GENERAL APPEARANCE		
MENTAL STATUS		
SKIN		
EYES		
EARS / HEARING EVALUATION		
NOSE		
MOUTH/PHARYNX		
NECK		
HEART		
LUNGS		
ABDOMEN		
EXTERNAL GENITALIA		
RECTUM		
EXTREMITIES		
NEUROLOGIC		

Any condition that would prevent student from entering the Lewistown Hospital School of Nursing program?

Any condition that would require accomodation?

Examining Health Care Provider: _____

Address _____