Heritage School of Midwifery Physical Health Form

To be completed by a licensed healthcare provider

Applicant Information:

Full Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Email Address: _____

Emergency Contact:

Name: _____

Relationship: _____

Phone Number: _____

1. General Health Information

Height: _____

Weight: _____

Blood Pressure: _____

Heart Rate: _____

Vision (with correction if applicable):

Right Eye: _____

Left Eye: _____

Hearing (normal/abnormal): _____

2. Medical History

Please indicate if you have a history of any of the following:

Chronic Diseases (e.g., diabetes, hypertension, asthma, etc.):

_____

Allergies (medications, environmental, etc.):

_____

Medications currently being taken:

_____

3. Physical Exam

Please indicate if the applicant shows signs of any of the following:

Cardiovascular System:

Normal / Abnormal (Specify): _____

Respiratory System:

Normal / Abnormal (Specify): _____

Musculoskeletal System:

Normal / Abnormal (Specify): _____

Neurological System:

Normal / Abnormal (Specify): _____

4. Physical Fitness for Midwifery Program

Is the applicant able to lift and carry heavy objects (e.g., medical equipment, supplies)? Yes / No

Is the applicant capable of standing for long periods and performing physical tasks during clinical rotations? Yes / No

Does the applicant have any physical limitations that could affect their performance during clinical placements (e.g., pregnancy, orthopedic issues)? Yes / No

If yes, please explain: _____

5. Psychological Health Assessment

Does the applicant have any psychological conditions that could affect their ability to perform the duties of a midwife (e.g., depression, anxiety, PTSD)? Yes / No

If yes, please provide details: _____

Is the applicant under any psychiatric care or treatment? Yes / No

If yes, please provide details:

_____

6. Provider's Statement of Fitness

Based on your examination, do you believe the applicant is physically and psychologically fit to pursue a career in midwifery and participate in clinical training?

Yes / No

If "No", please provide details: _____

Physician's Name: _____

Physician's Signature: _____

Date: _____

Disclaimer:

This form is to ensure that the applicant meets the necessary physical and mental health criteria to pursue midwifery training. All information provided will be kept confidential and used solely for admission purposes. By signing this form, the applicant and healthcare provider confirm the accuracy of the information provided.