Excellence Through Innovation

OLD DOMINION UNIVERSITY - SCHOOL OF NURSING
STUDENT PHYSICAL EXAMINATION FORM
RETURNING STUDENT

This form is to be completed during August. Please return a copy of this form to your clinical coordinator in the School of Nursing by the first day of classes in fall semester.

NAME: _____ **DATE OF BIRTH:**_____

ADDRESS: _____

UIN: _____ **PHONE:**_____

1) **All returning students: 2 step PPD series must be placed and read in August**

Please answer yes or no to the following:

_____ Since your last PPD review have you worked in a location where patients with active TB received care or services?

_____ Since your last PPD have you lived or had close contact with someone who has TB disease

_____ Since your last PPD have you had an abnormal CXR

_____ Since your last PPD has a healthcare practitioner told you that your immune system isn't working or can't fight infection?

_____ Since your last PPD have you traveled outside the USA, if so where?

_____ Since your last PPD have you had any of the below symptoms for more than 3 weeks at a time?

( ) Persistent cough
( ) Excessive weight loss
( ) Excessive sweating at night
( ) Persistent fever
( ) Hoarseness
( ) Excessive fatigue
( ) Coughing up blood
( ) None of the above

Student Signature_____ Date_____

2 step PPD series:

#1 Date Given _____ Date Read _____ Results _____

#2 Date Given _____ Date Read _____ Results _____

If new positive PPD, 1) current Chest X Ray required (attach results)

If past positive PPD, 1) document TB prophylaxis received and 2) Chest X Ray **within the past year** required (attach results)
AND 3) this individual is free of fever, night sweats, weight loss, loss of appetite, malaise, cough:
Yes, free of symptoms _____ Date _____

2) **All returning students: Have received the Tdap vaccine within 8 years_____ (please attach copy of vaccine record)**

3) **All returning 2nd year students: Hepatitis B antibody titer (Anti HBs) must be measured *unless* previously reported with initial physical exam for nursing.**

Staple photocopy of lab results to this form.

4) **All returning students must submit proof of valid CPR certification. Staple a *photocopy* of front and back of card to this document. CPR certification must be valid through August.**

Does this individual have any physical or mental conditions, disabilities or medical limitations that would prohibit the individual from functioning in the capacity of a Registered Nurse?

_____ NO

_____ YES Please explain:

PHYSICIAN / Health Care Provider:_____(signature)_____

ADDRESS: _____

PHONE: _____**DATE:** _____

Tuberculosis Surveillance and Vaccine Preventable Disease Immunity information supplied to Old Dominion University School of Nursing on your health physical form may be given to clinical facilities upon their request for such information. Failure to have the information supplied to clinical facilities would result in lack of clinical placement and failure in a clinical course. Your signature below indicates agreement with information being given to clinical agencies.

Student Printed Name_____

Student Signature_____

Date_____