D'Youville College School of Nursing Physical Examination Form

This form is an annual requirement for all nursing students enrolled in the DYC SON program. Please submit ALL pages of the completed form to CastleBranch and keep a copy for your records.

PAGES 1 AND 2 ARE TO BE COMPLETED AND SIGNED BY THE STUDENT. PAGES 3, 4, 5 ARE TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROFESSIONAL.

Student Demographics and Health History:

SSN #:_____ **Date of Birth:** _____

Name: _____
Last **First** **Middle**

Local Address: _____
Street **City**

_____ _____ (_____)_____
State **Zip Code** **Phone Number**

HEALTH INSURANCE COVERAGE

NAME OF COMPANY: _____

POLICY #:_____ **GROUP #:** _____

Please check those conditions for which you have a history:

___Anemia/Blood disorder	___Infectious Mononucleosis	___Back Pain
___Arthritis/Joint Problems	___Kidney/Urinary Problems	___Blood Producing Cough
___Asthma/Hayfever	___Fainting/Convulsions/Epilepsy	___Hepatitis
___Heart Disease/Murmur	___Skin Rashes/Sores	___Diarrhea
___Tuberculosis	___Draining Wounds/Infection	___Jaundice
___High Blood Pressure	___Hernia	___Change in Bowel Habits
___Diabetes	___Ulcer/Gastroenteritis	___Blood in your stools
___Allergies to Foods or Drugs	___Emotional Problems	___Cough

Student Demographics and Health History (cont.):

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

1. Are you currently under the care of a physician? ☐ Yes ☐ No

   If "Yes", please explain_____

   _____

2. Are you currently on any medication? ☐ Yes ☐ No

   If "Yes", please explain_____

   _____

3. Do you have any problems with your vision? ☐ Yes ☐ No

   If "Yes", please explain_____

   _____

4. Do you have any allergies to food, drugs, pollens, latex, etc.? ☐ Yes ☐ No

   If "Yes", please explain_____

   _____

5. How many colds have you had in the past year? _____ How long do they normally last? _____

6. Do you smoke? _____ What? _____ How many per day? _____

7. In the past year has there been any change in your:

   a. Weight? ☐ Yes ☐ No How much? _____

   b. Blood Pressure? ☐ Yes ☐ No How much? _____

Student Information Release and attestation:

I am aware and understand that in order to maintain the health and safety of their clients and meet designated health laws, agencies used for clinical experiences may require selected information from my health record. I authorize release of pages 3 and 4 of this form to said agencies and to the program office. I also concur that the information above, attested to by my physician, is true.

_____

Signature of Student **Date**

The following sections of this form MUST be complete by a Health Care Professional

PATIENT NAME:_____ DOB:_____

HEIGHT: WEIGHT: _____ BP: _____ PULSE: _____

Vision without corrective lenses: R: _____ L: Vision with corrective lenses: R: _____ L:_____

CHECK EACH ITEM IN PROPER COLUMN. ENTER "NE" IF NOT EVALUATED.

	Normal	Abnormal	Comments:
1. Head, Neck, Face, Scalp, Skin	☐	☐	
2. Ears, Nose & Throat	☐	☐	
3. Oral Cavity	☐	☐	
4. Lungs, Chest	☐	☐	
5. Heart	☐	☐	
6. Abdomen, Viscera	☐	☐	
7. Musculoskeletal	☐	☐	
8. Hearing	☐	☐	

Limitations, if any: _____

ALLIED HEALTH DEPARTMENTS' LIST OF REQUIRED IMMUNIZATIONS

1. Tuberculosis screening - PPD or quantiFERON Gold blood test required

NOTE: ***In keeping with current Centers for Disease Control recommendations*** **a 2-Step TB skin test (two TB skin tests administered 1-3 weeks apart) is required if this is first PPD or if previous PPD was more than 12 months ago. If student has previous PPDs documentation of TWO negative consecutive annual 1-Step TB skin tests within the last 13 months is required. If past positive PPD result, a clear chest x-ray (lab report required) is required.**

1st PPD Date Placed:_____
Date Read (must be within 48 – 72 hours of placement):

Result: ☐ Positive ☐ Negative Comments:_____

2nd PPD Date Placed:_____
Date Read (must be within 48 – 72 hours of placement):_____

Result: ☐ Positive ☐ Negative Comments:_____

– OR –

(If PPD is positive, CXR must be obtained and copy of the report must be uploaded to Certified Profile showing a clear CXR result, no evidence of TB)

Chest X-Ray (if positive PPD only) Date: _____ *Results:*_____

– OR –

quantiFERON Gold blood test (lab report required):

Date of test:_____

Result: ☐ Positive ☐ Negative Comments:_____

2. Rubella (Measles) Live Vaccine

Please Note*: For Mumps/Measles/Rubella Vaccines, must have documentation of either having received individual vaccines OR MMR vaccination previously. If prior vaccination documentation is not available, then documentation of immune serology for each component of the MMR vaccine is required on official lab report with reference ranges.*

1st Dose Date: _____ **2nd Dose** Date: _____

(Two doses of measles vaccination required, with first dose given on or after first birthday, and second dose separated by at least 28 days OR immune serology with lab report uploaded to Certified profile)

Rubella Titer (if needed): Date: _____ *Result:* _____

3. Mumps Vaccine

1st Dose Date: _____ **2nd Dose** Date: _____

(Two doses of mumps vaccination required, with first dose given on or after first birthday, and second dose separated by at least 28 days OR immune serology with lab report uploaded to Certified profile)

Mumps Titer (if needed): Date: _____ *Result:*

4. Rubella Live Vaccine

1st Dose Date: _____ **2nd Dose** Date: _____

(Two doses of rubella vaccination required, with first dose given on or after first birthday, and second dose separated by at least 28 days OR immune serology with lab report uploaded to Certified profile)

Rubella Titer (if needed): Date: _____ *Result:* _____

5. Tetanus/diphtheria/acellular pertussis [Tdap] (within 10 years)

Date:

(In keeping with current Centers for Disease Control recommendations, health care personnel younger than age 65 with direct patient contact who have not previously received a dose of Tdap, should receive a single dose of Tdap to replace one Td booster dose. **Waiting at least 2 years since last Td booster is suggested.**)

6. Hepatitis B Series:

1st Dose Date: **2nd Dose** Date: **3rd Dose** Date: _____

Hepatitis B Titer (if needed): Date: _____ *Result:* _____

7. Varicella Zoster Vaccine:

1st Dose Date: **2nd Dose D**ate: _____

History of Chicken Pox (date required): _____

Varicella Titer (if needed): Date: _____ *Result:* _____

(All persons age 13 years and older without evidence of immunity to varicella, or documented history of having chickenpox are required to have two doses of varicella vaccine, separated by at least 4 weeks.)

8. Influenza Vaccine (annual requirement)

Date: _____

(In keeping with current Centers for Disease Control recommendations, it is recommended that all health care personnel without known contraindications should receive an annual influenza vaccine. If individual cannot receive the vaccine for any medically indicated or personal reason, they may sign the flu declination waiver found on CastleBranch in place of a vaccine and will be required to wear a mask in all clinical facilities as outlined by their policy during flu season.)

_____

Healthcare Provider Signature **Date**

_____

Print Name or Stamp here

_____(_____)_____

Address **Phone Number**