FACULTY PHYSICAL EXAMINATION

Student Health Service
One Education Drive
Garden City, NY 11530
516-572-7123

*Physical exam, TB testing, should begin 90 days prior to 1st day of class
*Make copies of ALL Physical, Vaccination & Lab reports
*Original form is submitted to NCC Health Office

20_____Nursing

20_____Allied Health Science Program _____
(Program)

A. NAME: _____
(Print) Last First M.I.

ADDRESS: _____ _____ _____ _____
Street Address City State Zip Code

PHONE: (_____) _____ DOB: _____ Age: _____ Sex: _____

NCC I.D. # _____

B. **PERSONAL HISTORY** - (To be filled out by faculty)

	Yes	No		Yes	No		Yes	No
Rheumatic Fever			Hernia			High Blood Pressure		
Heart Disease			Asthma			Convulsive Disorder		
Tuberculosis			Kidney Disease			Speech Disorder		
⊕ TB Skin Test			Hepatitis			Allergies		
Orthopedic Problem			Sickle Cell Disease/Trait			Latex Allergy		
Diabetes			Fainting			Vision Problems		
Other								

Medications: _____

Signature: **X** _____

C. **CLINICAL EVALUATION** - (To be completed by physician) – Write findings. **No check (√) marks.**

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Head		Chest-Lungs		Menses	
Skin		Heart		Cardiovascular	
Eyes		Breast		Endocrine System	
Nose		Abdomen		Lymphatic System	
Throat		Hernia		Neurological	
Teeth		Genitalia (Male)		Spine-Musculoskeletal	
Ears		Pelvic (Optional)		Lower Extremities	
Neck-Thyroid		Ano-Rectal		Upper Extremities	

Required Annually (at the time of physical) - (Two Step PPD Testing for initial Tuberculin Skin Testing)

Tuberculin Test (PPD Intradermal Only)

OR Quantiferon TB Gold Test (attach lab copy) Result: _____

PPD Date Given _____ PPD Date Read (48-72HRS) _____ PPD Result (in mm) _____

PPD Date Given _____ PPD Date Read (48-72HRS) _____ PPD Result (in mm) _____

Newly Positive ⊕ PPD or Quantiferon require CXR (attach CXR report) Date/Result:_____

OR If you have a History of ⊕ PPD (MANTOUX) Test: Date/Year _____

History of POSITIVE reactors to TB Test must submit **Chest X-ray report** within two years (attach CXR report) Date_____ Result: _____

NCC-ID#: N00_____ NAME: _____
Print (Last) (First) (M.I.)

Required on Initial Physical Only:

Documentation of Immunity to Measles, Mumps, Rubella and Varicella by blood antibody testing or adequate documentation of immunizations required (attach labs)

Measles/Rubeola Titer_____ Date: _____Result: _____**OR** Vaccine 1st Date_____ 2nd Date _____
Mumps Titer _____Date: _____Result: _____**OR** Vaccine 1st Date_____2nd Date_____
Rubella Titer _____Date: _____Result: _____**OR** Vaccine Date_____
Varicella Titer_____Date: _____Result: _____**OR** Vaccine 1st Date_____ 2nd Date _____

Polio Salk-Sabin (any history) Date: _____

Tdap or Td Booster within ten years, Date: _____

Hepatitis B Vaccine: 1st Date: _____ 2nd Date: _____3rd Date: _____ or Titer: _____

IMMUNIZING AGAINST HEPATITIS B IS STRONGLY ADVISED PRIOR TO THE START OF CLINICAL ROTATIONS OR A DECLINATION STATEMENT MUST BE SIGNED.

DECLINATION STATEMENT

I understand that I may be exposed to blood or other potentially infectious materials and I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been informed of the need to be vaccinated with Hepatitis B vaccine. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccination, I continue to be at risk of acquiring Hepatitis B, a serious disease. I understand that Nassau Community College cannot mandate that I take this vaccination. I further understand and agree that I cannot hold Nassau Community College responsible for any injury or illness arising from my activity and/or exposure to blood or other blood-borne pathogens in my program and clinical laboratories.

Name (Print): _____

Student Signature: **X**_____ Date: _____

PHYSICIAN'S CERTIFICATION:

Is this the first time you have seen this patient? Yes_____ No_____

Provider Please Check: ☐ CLEARED FOR PROGRAM or ☐ NOT CLEARED FOR PROGRAM

I hereby certify that _____ has been examined by me in accordance with New York State Health Department guidelines. In my opinion, the above named is free from contagious disease and appears physically and emotionally fit to perform the duties of his/her position.

_____

_____

_____

_____

Physician's Signature _____ ** Date _____

****Do Not Date Physical until PPD is Read**

Physician's Name (Print) _____ License No. _____

Physician's Stamp _____ Phone (_____) _____

Address: _____

(ALL INFORMATION IS CONFIDENTIAL)

(Rev. 06/15)