Nassau Community College
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NASSAU COMMUNITY COLLEGE
STATE UNIVERSITY OF NEW YORK

OFFICE USE ONLY
Semester-
Registered -
Identification-
Date B/S given-
RN-

All Nursing/Allied Health students must complete this form prior to participating in clinicals.

ALLIED HEALTH/NURSING PHYSICAL FORM

Allied Health (Please complete)

20_____ 1st Year _____
(Area of study)
20_____ 2nd Year _____
(Area of study)

Nursing (Please complete)

20_____ 1st Year: 101_____ 105 _____
20_____ 2nd Year: 203_____ 204 _____

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

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

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

B. **PERSONAL HISTORY** - (To be filled out by student, Each box must be checked)

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

Medications: _____
(If none, write NONE)

Signature: **X** _____

C. **CLINICAL EVALUATION** - (To be completed by health care provider)

Height _____ Weight _____ Blood Pressure _____ Pulse _____

System	Satisfactory	Unsatisfactory	Details If Unsatisfactory
General Appearance			
HEENT			
Respiratory			
Cardiovascular			
Abdomen			
Genitourinary (male)			
Musculoskeletal			
Skin			
Neurovascular			
Endocrine			
Extremities			

Tuberculin Screening Test: PPD Intradermal Skin Test (If it is your **FIRST PPD at NCC**, it MUST be a **TWO STEP PPD**)

#1 PPD Date Given _____ PPD Date Read (48-72HRS) _____ PPD Result (in mm) _____
#2 PPD Date Given _____ PPD Date Read (48-72HRS) _____ PPD Result (in mm) _____
Second PPD must be given at least 1 week after the 1st PPD was planted.

OR Quantiferon/ IGRA blood test (attach lab copy) Date: _____ Result: _____

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

OR History of ⊕ PPD Test: Date: _____

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. ***Dated original lab report MUST be attached.***

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 1stDate:_____ 2nd Date: _____

Tdap or Td Booster within ten years, _____

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

ALLIED HEALTH AND NURSING STUDENTS ARE ADVISED TO BE IMMUNIZED WITH HEPATITIS B VACCINE PRIOR TO THE BEGINNING OF CLINICAL PRACTICE OR MUST SIGN A DECLINATION STATEMENT.

DECLINATION STATEMENT

I understand that during my participation in my clinical internship, 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 in order to continue my education in my chosen health science program. My failure to be immunized could jeopardize the successful fulfillment of the requirements of my program at Nassau Community College, which may preclude me from graduating. 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:

I hereby certify that the above named person is in good health as determined by a recent physical examination of sufficient scope to ensure that he or she is free from health impairments which may be of potential risks to patients and other personnel or which may interfere with the performance of his or her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior. This individual is able to participate in their clinical learning experiences.

Provider Please √ Check: □ CLEARED FOR PROGRAM or □ NOT CLEARED FOR PROGRAM

_____
_____
_____
_____

Physician's Signature _____ ** **Date:** _____
**Do Not Date Physical until PPD is Read
Physician's Name (Print) _____ License No. _____
Physician's Stamp (Required) _____Phone (_____)_____
Address: _____
(Rev. 3/17) (ALL INFORMATION IS CONFIDENTIAL)

STUDENTS MUST ENSURE THEY HAVE PHOTOCOPIES OF ALL PAPERWORK BEFORE HANDING IN FOR BLUE SLIP. CLINICAL INSTRUCTORS AND FACILITIES WILL REQUIRE COPIES LATER ON. THE HEALTH OFFICE WILL NOT MAKE COPIES IF STUDENTS FAIL TO DO SO."