

To: Nursing Students/Applicants  
From: Terianne Darragh, BSN, RN  
Nursing Supervisor, Health Center  
Re: Nursing Physical Forms

Please review your physical forms before leaving your healthcare provider's office. Make sure all fields are filled out correctly. The forms will not be reviewed or accepted in the Health Center if there are any blank fields noted.

**Note: Students applying to the Nursing Program who do not submit completed physical by June 4, 2008 will not be considered for acceptance into the Nursing Program.**

**PPD** – if your PPD is positive, please attach a copy of the chest x-ray report.

**Polio** - your healthcare provider may write “childhood immunization” in the field if you received the polio immunization as a child.

**Varicella** – the form must have a titer value (number) that constitutes immunity. If the titer value does not constitute immunity please provide vaccination date. Varicella vaccine must be given 30 days prior to starting your clinical rotation. (Please attach a copy of the Lab report)

**Measles, Mumps and Rubella** – the form must have titer values that constitute immunity. If the titer value does not constitute immunity, please provide vaccination/s dates. (Please attach a copy of the Lab report)

**Hepatitis B** - the hepatitis B titer is recommended to verify immunity, but only if all three doses have been received 30 days prior to the blood test. (Please attach a copy of the Lab report)

**Urine drug screen** - Lab results must be submitted with the nursing physical forms.

Your healthcare provider **must sign and stamp all pages** with which information was provided by him/her.

If you would like to have your nursing physical done at the Health Center please make an appointment by calling the telephone number below as soon as possible. There is no charge for the physical or vaccinations. There is a reduced fee for lab test done off campus for College of Staten Island students who do not have health insurance benefits.

When all the above have been satisfied, you may submit your completed nursing physical forms to the Health Center in the Campus Center (1C) Room 112 for review. We will not accept faxes or mailed forms, unless the student lives outside of the tri-state region. Please make at least 3 copies of all documents before submitting them to the Health Center and keep them for your records. If you have any questions you can contact the Health Center by stopping in at the above location or by calling 1(718) 982-3045. I greatly appreciate your cooperation.

Terianne Darragh, BSN, RN  
Nurse Supervisor

**PHYSICAL EXAMINATION**

	<b>College of Staten Island</b> <b>The City University of New York</b> <b>Tomas D. Morales, President</b>	<b>College Health Center</b> <b>2800 Victory Blvd, Bldg 1C, Room112</b> <b>Staten Island, NY 10314</b>	<b>Telephone 1.718.982.3045</b> <b>Fax 1.718.982.2966</b> <b>TTY 1.718.982.3315</b>
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NAME (PLEASE PRINT)      LAST      FIRST

ADDRESS      CITY      STATE      ZIP

DATE OF BIRTH (MONTH/DAY/YEAR)      SOCIAL SECURITY # (OR STUDENT ID#)      PHONE

DATE OF ENROLLMENT (MONTH/DAY/YEAR)

**Degree Pursuing**       AAS       BS       MS      **Sex**       Male       Female

CONDITION	YES	NO	CONDITION	YES	NO
Hearing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Worry or Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergy / Hayfever	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problem	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis or Treatment to Prevent	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Cysts, Tumor, etc.	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Intestine or Stomach Problem	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Infection	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Pelvic Infection	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Disease	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>

- |   | YES                      | NO                       |   |
|---|--------------------------|--------------------------|---|
| 1. Do you have health insurance?                | <input type="checkbox"/> | <input type="checkbox"/> | NAME OF INSURER _____                       |
| 2. Do you have a disability?                    | <input type="checkbox"/> | <input type="checkbox"/> | _____                                       |
| 3. Have you ever had a serious illness?         | <input type="checkbox"/> | <input type="checkbox"/> | EXPLAIN ALL YES ANSWERS (PLEASE GIVE DATES) |
| 4. Have you ever had a broken bone?             | <input type="checkbox"/> | <input type="checkbox"/> | _____                                       |
| 5. Have you ever had an operation?              | <input type="checkbox"/> | <input type="checkbox"/> | _____                                       |
| 6. Are you taking any medications?              | <input type="checkbox"/> | <input type="checkbox"/> | _____                                       |
| 7. Are you currently being treated by a clinic? | <input type="checkbox"/> | <input type="checkbox"/> | _____                                       |

IN CASE OF EMERGENCY NOTIFY (THIS SHOULD BE SOMEONE LOCAL)      PHONE

STUDENT SIGNATURE      DATE



**PHYSICAL EXAMINATION**

Student Name \_\_\_\_\_ SS# \_\_\_\_\_ Date: \_\_\_\_\_

TEST	RESULT							
PPD	NEGATIVE _____ POSITIVE _____ DATE _____ IF POSITIVE, DATE OF CHEST X-RAY _____ RESULTS OF CHEST X-RAY _____ (attach copy of report)							
DT BOOSTER WITHIN LAST 10 YEARS	DATE OF LAST DT BOOSTER _____							
POLIO IMMUNIZATION	DATE OF POLIO IMMUNIZATION _____							
VARICELLA	TITER VALUE _____ DOES THIS TITER CONSTITUTE IMMUNITY TO VARICELLA? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>Note: Equivocal titers not accepted. Attach copy of Lab Report.</b>							
	IF NON -IMMUNE: DATE OF VARICELLA VACCINATION: _____ <b>Note: * Vaccination must be received no less than 30 days prior to                      start of clinical rotation.                      * Repeat titers are required 30 days after vaccination.</b>							
MEASLES	TITER VALUE _____ DOES THIS TITER CONSTITUTE IMMUNITY TO MEASLES? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>Note: Equivocal titers not accepted. Attach copy of Lab Report.</b>							
MUMPS	TITER VALUE _____ DOES THIS TITER CONSTITUTE IMMUNITY TO MUMPS? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>Note: Equivocal titers not accepted. Attach copy of Lab Report.</b>							
RUBELLA	TITER VALUE _____ DOES THIS TITER CONSTITUTE IMMUNITY TO RUBELLA? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>Note: Equivocal titers not accepted. Attach copy of Lab Report.</b>							
HEPATITIS B VACCINE	<table border="0"> <tr> <td style="width: 20px;">1.</td> <td>_____</td> <td rowspan="3" style="vertical-align: top;">                             If not vaccinated against                              Hepatitis B, a statement of                              declination will be signed in                              clinical                         </td> </tr> <tr> <td>2.</td> <td>_____</td> </tr> <tr> <td>3.</td> <td>_____</td> </tr> </table>	1.	_____	If not vaccinated against Hepatitis B, a statement of declination will be signed in clinical	2.	_____	3.	_____
1.	_____	If not vaccinated against Hepatitis B, a statement of declination will be signed in clinical						
2.	_____							
3.	_____							
DRUG SCREEN (URINE) RESULT _____ DATE TESTED _____ <b>(Attach copy of Lab Report)</b>								

**Date of last complete physical examination** \_\_\_\_/\_\_\_\_/\_\_\_\_

THE ABOVE NAMED STUDENT HAS BEEN MEDICALLY CLEARED TO PARTICIPATE IN  
 CLINICAL ROTATION SUPERVISED BY THE DEPARTMENT OF NURSING AT THE COLLEGE  
 OF STATEN ISLAND

\_\_\_\_\_  
 HEALTH CARE PROVIDERS NAME AND TITLE (PLEASE PRINT)

\_\_\_\_\_  
 HEALTH CARE PROVIDERS SIGNATURE AND STAMP      DATE  
 Affix Health Care Providers **Stamp** Here