PHYSICAL EXAMINATION

College of Staten Island The City University of New York Health & Wellness Services	**Health & Wellness Services** **2800 Victory Blvd, 1C, Room 112** **Staten Island, NY 10314**	**Telephone 1.718.982.3045** **Fax 1.646.664.3987** **TTY 1.718.982.3315**

Program: □ **AAS** □ **BS** □ **NP** □ **DNP** □ **New Student** □ **Continuing Student**

Last Name **First Name**

Address **City** **State** **Zip code**

Date of Birth **EMPL ID #** **Phone #**

TEST	RESULT
TUBERCULOSIS SCREENING **(Quantiferon within 1 year)**	**QUANTIFERON** DATE_____ NEGATIVE_____INDETERM_____POSITIVE _____ (**Attach copy of lab report)** IF POSITIVE, DATE OF CHEST X-RAY _____ CXR RESULTS_____(**Attach copy of CXR report)**
Tdap BOOSTER **(must be within last 10 years)**	DATE OF LAST Tdap BOOSTER _____
FLU VACCINE	DATE OF FLU IMMUNIZATION _____
VARICELLA VACCINE 1. _____ 2._____OR	TITER VALUE (**IGG**) DOES THIS TITER CONSTITUTE IMMUNITY TO VARICELLA? □ **YES** □ **NO** **Equivocal/Negative titers not accepted (Attach copy of Lab Report)**
RESPIRATORY FIT TEST CLEARANCE (***Date will grant medical clearance for student to be fit tested at the College of Staten Island)***	DATE _____

Last Name **First Name** **Date of Birth**

TEST	RESULT
MEASLES VACCINE 1. _____ 2._____ OR	TITERVALUE (**IGG**) _____DOES THIS TITER CONSTITUTE IMMUNITY TO MEASLES? □ **YES** □ **NO** **Equivocal/Negative titers not accepted (Attach copy of Lab Report)**
MUMPS VACCINE 1. _____ 2._____ OR	TITERVALUE (**IGG**)_____DOES THIS TITER CONSTITUTE IMMUNITY TO MUMPS? □ **YES** □ **NO** **Equivocal/Negative titers not accepted (Attach copy of Lab Report)**
RUBELLA VACCINE 1. _____ 2._____ OR	TITERVALUE **(IGG)** _____DOES THIS TITER CONSTITUTE IMMUNITY TO RUBELLA? □ **YES** □ **NO** **Equivocal/Negative titers not accepted (Attach copy of Lab Report)**
(***or***) MMR VACCINE	1._____ 2. _____
COVID VACCINE MANUFACTURER	1._____ 2. _____ _____ _____
HEPATITIS B VACCINE 1. _____ 2. _____ 3. _____	**Equivocal/Negative titers not accepted (Attach copy of Lab Report)**
CASTLE BRANCH URINE DRUG SCREEN **(within 3 months)**	DATE TESTED_____RESULT _____ **(Attach Copy of Lab Report)**

	TITER VALUE	**NEGATIVE DATE**	**EQUIVOCAL DATE**	**POSITIVE DATE**
HbsAg				
HbcAB				
HbsAB				

I certify that the above student has had a complete physical examination and risk assessment that is of sufficient scope to ensure that the participant is free from any health impairment which is of potential risk to patients or which might interfere with the performance of their duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior. As such, this student is cleared to participate in clinical rotations at a hospital, nursing home, community or private health facility supervised by the College of Staten Island's Nursing Program faculty.

Health Care Provider's Name and Title **Date of Clearance**

Address **Telephone Number**

Health Care Provider's Signature and Stamp