Health & Wellness Services, Division of Student Affairs- Health Center, 1C-Room112

It is strongly advised students make an appointment with their primary care provider or Health Center nurse practitioner at least one month prior to the due date of the physical. Results from lab tests may require several follow-up visits to complete the requirements to be considered. Physical exams done in the Health Center are free (*see below for more information).

Students applying to the Nursing Program who do not submit a completed physical by May 24, 2018 will not be considered for acceptance into the Nursing Program

Please review your physical form before leaving your healthcare provider’s office. Make sure all fields are filled out correctly. The form will not be reviewed or accepted in the Health Center if there is any missing information.

The physical exam is to include, height, weight, b/p, vision, hemoglobin/hematocrit and urine for glucose and protein. Results are to be documented on the top of page 2.

Page 3 to include:

Tuberculosis Screening- PPD and/or Quantiferon (must submit one of the below)
- A negative PPD (TST-tuberculin skin test) done within one year
- A positive PPD or hx of positive PPD with negative chest x-ray (attach copy of x-ray report)
- A negative Quantiferon test done within the year (attach copy of lab report). A positive result requires a negative chest x-ray (attach copy of x-ray report).

Td/Tdap:
- Must be within 10 years.

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

Varicella:
- A titer value (number) that constitutes immunity OR 2 vaccination dates 28 days apart. Varicella vaccine must be given 30 days prior to starting your clinical rotation (attach copy of lab report).

Measles, Mumps and Rubella:
- A titer value (number) that constitutes immunity OR 2 vaccination dates 28 days apart (attach copy of lab report/s).

Hepatitis B:
- Hepatitis B surface antibody titer is recommended to verify immunity. Documentation of 3 doses of hepatitis B is acceptable. You do not need to have all three doses of hepatitis B to be considered for the program. Hepatitis B vaccine is recommended, however can be declined.

Urine drug screen (UDS):
- UDS requires an 11 or greater panel of abuse/recreational drugs. A copy of the lab results must be submitted with the nursing physical form. PLEASE NOTE: All positive UDS results will be reported to the Nursing Department. All positive UDS tests collected and sent by the Health Center NP, require confirmatory testing and will incur additional costs to the student, as per laboratory fee.

Please note: Equivocal/Negative titers are not accepted. Titers must be positive. If titers are equivocal or negative, you must provide proof of the appropriate vaccination/s.

*Your healthcare provider must sign, stamp and date pages 2 and 3. 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. Free MMR, tetanus and hepatitis B vaccines are available in the Health Center. If you do not have health insurance, lab tests can be done at the Health Center at a reduced fee.

When all the above has been satisfied, you may submit your completed nursing physical form to the Health Center located in the Campus Center (1C), Room 112, between the hours 10am-11:30am and 2:00pm-3:30pm for review. Appointments are recommended. We will not accept faxed or mailed forms. 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 or to make an appointment, you can contact the Health Center by stopping in at the above location or by calling 1.718.982.3045. Thank you for your cooperation.

Revised 5/18/2017
# PHYSICAL EXAMINATION

![Logo](image)

**Health & Wellness Services**
2800 Victory Blvd, 1C, Room 112
Staten Island, NY 10314

**Telephone** 1.718.982.3045
**Fax** 1.718.982.2966
**TTY** 1.718.982.3315

---

**NAME (PLEASE PRINT)**

**LAST**

**FIRST**

**ADDRESS**

**CITY**

**STATE**

**ZIP**

**DATE OF BIRTH (MONTH/DAY/YEAR)**

**EMPL ID#**

**PHONE**

**Degree Pursuing:**

- [ ] AAS
- [ ] BS
- [ ] MS

**Gender:**

- [ ] Male
- [ ] Female

---

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

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1. **Do you have health insurance?**
   - [ ] Yes
   - [ ] No
   - [ ] Name of Insurer

2. **Do you have a disability?**
   - [ ] Yes
   - [ ] No
   - Explain all yes answers (please give dates):

3. **Have you ever had a serious illness?**
   - [ ] Yes
   - [ ] No

4. **Have you ever had a broken bone?**
   - [ ] Yes
   - [ ] No

5. **Have you ever had an operation?**
   - [ ] Yes
   - [ ] No

6. **Are you taking any medications?**
   - [ ] Yes
   - [ ] No

7. **Are you currently being treated by a clinic?**
   - [ ] Yes
   - [ ] No

---

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

**PHONE**

**STUDENT SIGNATURE**

**DATE**

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Revised 5/18/2017
### PHYSICAL EXAMINATION

**Student Name:** ___________________________  **Date of Birth:** ___________  **EMPLID#:** ___________

| HEIGHT (in.) | WEIGHT (lbs.) | B/P
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>VISION-O.S.</td>
<td>UA: Protein</td>
<td>UA: Glu.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Body System</th>
<th>NORMAL</th>
<th>ABNORMAL</th>
<th>NOT EXAMINED</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEAD, NOSE, SINUSES, NECK, THYROID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MOUTH, THROAT, TEETH and GUMS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EYES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EARS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SKIN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHEST, BREASTS, LUNGS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEART and VASCULAR SYSTEM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENDOCRINE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LYMPHATIC SYSTEM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABDOMEN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HERNIA</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>SPINE and MUSCULOSKELETAL</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>NEUROPSYCHIATRIC</td>
<td></td>
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<tr>
<td>GENITO-URINARY</td>
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<td>ANUS and RECTUM</td>
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</tr>
<tr>
<td>SUMMARY</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Is the student currently under a physician’s care or taking medications?  ☐ NO  ☐ YES

(SPECIFY)

Is this student currently being monitored for any of the following illnesses?

1) Emotional  ☐ NO  ☐ YES
2) Mental  ☐ NO  ☐ YES
3) Physical  ☐ NO  ☐ YES

Please Specify

---

**COMMENTS**

**HEALTH CARE PROVIDER’S NAME AND TITLE (PLEASE PRINT)** ___________________________

**DATE OF PHYSICAL** ___________________________

**ADDRESS**

**HEALTH CARE PROVIDER’S SIGNATURE AND STAMP**

(Any corrections or changes to original information entered must be signed by health care provider)
# PHYSICAL EXAMINATION

**Student Name:** ___________________________  **Date of Birth:** ___________________  **EMPLID #:** ___________________

<table>
<thead>
<tr>
<th>TEST</th>
<th>RESULT</th>
</tr>
</thead>
</table>
| **TUBERCULOSIS SCREENING** (PPD and Quantiferon tests must be within 1 year) | PPD  
DATE _______ NEGATIVE _______ POSITIVE _______  
IF POSITIVE, DATE OF CHEST X-RAY _______  
CXR RESULTS ________________ (Attach copy of CXR report)  
QUANTIFERON  
DATE _______ NEGATIVE ___ INDETERM ___ POSITIVE ___  
(Attach copy of lab report)  
IF POSITIVE, DATE OF CHEST X-RAY _______  
CXR RESULTS ________________ (Attach copy of CXR report) |
| Td OR Tdap BOOSTER (must be within last 10 years) | DATE OF LAST Td/Tdap BOOSTER _______  
(Circle one) |
| **POLIOIMMUNIZATION** | DATE OF POLIOIMMUNIZATION ___________________ |
| **VARICELLA VACCINE** | TITER VALUE _________ DOES THIS TITER CONSTITUTE IMMUNITY TO VARICELLA?  
□ YES  □ NO  
Note: Equivocal/Negative titers not accepted (Attach copy of Lab Report) |
| 1. ________________  
2. ________________ OR |
| **MEASLES VACCINE** | TITER VALUE _________ DOES THIS TITER CONSTITUTE IMMUNITY TO MEASLES?  
□ YES  □ NO  
Note: Equivocal/Negative titers not accepted (Attach copy of Lab Report) |
| 1. ________________  
2. ________________ OR |
| **MUMPS VACCINE** | TITER VALUE _________ DOES THIS TITER CONSTITUTE IMMUNITY TO MUMPS?  
□ YES  □ NO  
Note: Equivocal/Negative titers not accepted (Attach copy of Lab Report) |
| 1. ________________  
2. ________________ OR |
| **RUBELLA VACCINE** | TITER VALUE _________ DOES THIS TITER CONSTITUTE IMMUNITY TO RUBELLA?  
□ YES  □ NO  
Note: Equivocal/Negative titers not accepted (Attach copy of Lab Report) |
| 1. ________________  
2. ________________ OR |
| **MMR VACCINE** | TITER VALUE  
1. _________  
2. _________ |
| **HEPATITIS B VACCINE** | TITER VALUE  
1. _________  
2. _________  
3. _________ |
| **DRUG SCREEN (URINE)** (must be within 1 year) | DATE TESTED _________ RESULT _________  
(Attach Copy of Lab Report) |

The above named student has had a risk assessment and physical and is able to participate in clinical rotation supervised by the College of Staten Island Department of Nursing, as of ___________________________.

**DATE HEALTH CARE PROVIDER NAME AND TITLE (PLEASE PRINT)**

__________________________

Affix Health Provider’s Stamp Here

Revised 9/16