College of Staten Island
The City University of New York

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 December 19, 2019 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).**

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.

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 1.718.982.2966** **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**

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

		YES	NO	
1.	**Do you have health insurance?**	□	□	**NAME OF INSURER**
2.	**Do you have a disability?**	□	□	**EXPLAIN ALL YES ANSWERS (PLEASE GIVE DATES):**
3.	**Have you ever had a serious illness?**	□	□	
4.	**Have you ever had a broken bone?**	□	□	
5.	**Have you ever had an operation?**	□	□	
6.	**Are you taking any medications?**	□	□	
7.	**Are you currently being treated by a clinic?**	□	□	

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

STUDENT SIGNATURE **DATE**

PHYSICAL EXAMINATION

Student Name:_____ Date of Birth:_____ EMPLID#: _____

HEIGHT (in.)	**WEIGHT (lbs.)**	**B/P**		
VISION-O.D.	**Hgb. Or Hct.**			
VISION-O.S.	**UA: Protein**	**UA: Glu.**		
		NORMAL	**ABNORMAL**	**NOTEXAMINED**
HEAD, NOSE, SINUSES, NECK THYROID		☐	☐	☐
MOUTH, THROAT, TEETH and GUMS		☐	☐	☐
EYES		☐	☐	☐
EARS		☐	☐	☐
SKIN		☐	☐	☐
CHEST, BREASTS, LUNGS		☐	☐	☐
HEART and VASCULAR SYSTEM		☐	☐	☐
ENDOCRINE		☐	☐	☐
LYMPHATIC SYSTEM		☐	☐	☐
ABDOMEN		☐	☐	☐
HERNIA		☐	☐	☐
SPINE and MUSCULOSKELETAL		☐	☐	☐
NEUROPSYCHIATRIC		☐	☐	☐
GENITO-URINARY		☐	☐	☐
ANUS and RECTUM		☐	☐	☐
SUMMARY		☐	☐	☐

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#: _____

TEST	RESULT
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)**
Tdap BOOSTER **(must be within last 10 years)**	DATE OF LAST Tdap BOOSTER _____
POLIOIMMUNIZATION	DATE OF POLIO IMMUNIZATION _____
VARICELLA VACCINE 1. _____ 2._____ OR	TITER VALUE_____ DOESTHISTITERCONSTITUTE IMMUNITYTOVARICELLA? □ **YES** □ **NO** **Note: Equivocal/Negative titers not accepted (Attach copy of Lab Report).****Varicella vaccination must be received no less than 30 days prior to start of clinical rotation.**
MEASLES VACCINE 1. _____ 2._____ OR	TITER VALUE_____ DOESTHISTITER CONSTITUTE IMMUNITY TO MEASLES? □ **YES** □ **NO** **Note: Equivocal/Negative titers not accepted (Attach copy of Lab Report)**
MUMPS VACCINE 1. _____ 2._____ OR	TITER VALUE_____ DOESTHISTITER CONSTITUTE IMMUNITY TO MUMPS? □ **YES** □ **NO** **Note: Equivocal/Negative titers not accepted (Attach copy of Lab Report)**
RUBELLA VACCINE 1. _____ 2._____ OR	TITER VALUE_____ DOESTHISTITER CONSTITUTE IMMUNITY TO RUBELLA? □ **YES** □ **NO** **Note: Equivocal/Negative titers not accepted (Attach copy of Lab Report)**
(***or***) MMR VACCINE	1._____ 2. _____
HEPATITIS B VACCINE 1. _____ 2. _____ 3. _____	**TITER VALUE** / **NEGATIVE** / **EQUIVOCAL** / **POSITIVE** HbsAg HbcAB HbsAB **Note: Equivocal/Negative titers not accepted (Attach copy of Lab Report)**
DRUGSCREEN (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)

_____

HEALTH CARE PROVIDER SIGNATURE AND STAMP DATE

Affix Health Provider's Stamp Here