

TRINITAS SCHOOL OF NURSING

Physical Examination Form

Print Clearly

Name (Last) _____ (First) _____ Middle Initial _____

Fall Semester _____ Spring Semester _____ UCC ID # _____

Course: NURE _____

Birth Date _____ Male _____ Female _____

Address _____

City _____ State _____ Zip Code _____

Home Phone# _____ Cell # _____ Work # _____

STUDENT: Please check all items that apply to you:

- | | |
|--------------------------------|------------------------------------|
| _____ Allergies | _____ High blood pressure |
| _____ Asthma | _____ Migraine or severe headaches |
| _____ Arthritis or Rheumatism | _____ Hepatitis |
| _____ Back Injuries | _____ Bronchitis or Chronic cough |
| _____ Chest pains | _____ Psychiatric disorder |
| _____ Chronic back pain | _____ Heart disease |
| _____ Convulsions | _____ Tuberculosis |
| _____ Diabetes | _____ Surgery |
| _____ Dizzy spells or fainting | _____ Epilepsy |
| _____ Hearing problems | _____ Any other serious illness |

State details for all items check above: _____

List present medications: _____

I certify that to my knowledge I have had no injury, illness or ailment other than specified and permit the examining Health Care Provider to submit a medical report including test results to Trinitas School of Nursing.

Signature

Date

Name: _____ Date: _____

TRINITAS SCHOOL OF NURSING --- STUDENT HEALTH RECORD

TO BE COMPLETED BY PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT

Weight _____ Height _____ Pulse _____ Resp. _____ B/P _____

PHYSICAL FINDINGS

General Appearance	
Skin	
Hair	
Eyes	Visual Acuity: Without Correction, Right _____ Left _____ With Correction, Right _____ Left _____
Ears	Hearing Acuity: Right _____ Left _____
Nose	
Mouth	
Throat/Neck	
Respiratory	
Cardiovascular	
Breasts/Axilla	
Abdomen/Hernia	
Genitalia	
Musculoskeletal	
Neurological	
Psychological	
Endocrine	
Lymph Nodes	
Hematological	

Flu Vaccine Date: _____

Two-step Mantoux # 1: Date: _____ Result: _____ mm Interpretation () Negative () Positive

Mantoux #2: Date: _____ Result: _____ mm Interpretation () Negative () Positive

Quantiferon-TB Gold Blood Test Results () Negative () Positive

If Positive: Date Chest X-Ray _____ Chest X-Ray Result _____

Treatment _____

I have examined _____ (student) and found no indication of any disease or condition which might affect the health and safety of the student or the health and safety of the clients whom the student may provide care to. This student can fully participate in the clinical rotation with

No Limitations Limitations _____

Signature: _____ Date: _____

(Health Care Provider)

Name of HCP (PLEASE PRINT) _____

Address _____ City _____ State _____

Phone # _____ Fax _____

MD/NP/PA STAMP:

Name: _____ Date: _____

TRINITAS SCHOOL OF NURSING -- STUDENT HEALTH RECORD

TO BE COMPLETED BY HEALTH CARE PROVIDER

A COPY OF THE ACTUAL LABORATORY TITER RESULTS MUST BE SUBMITTED WITH THIS FORM

Rubeola Titer _____ { } Immune
{ } Non-Immune: Vaccine required Date Given _____

Mumps Titer _____ { } Immune
{ } Non-Immune: Vaccine required Date Given _____

Rubella Titer _____ { } Immune
{ } Non-Immune: Vaccine required Date Given _____

Varicella Titer _____ { } Immune
{ } Non-Immune: Vaccine required Date Given _____

HBsAb Titer _____ { } Negative: If Negative Vaccination Recommended or Declination signed
{ } Positive

HBsAg Titer _____ { } Negative
{ } Positive: If Positive MD Counseled and Cleared Date _____

Hepatitis C _____ { } Negative
{ } Positive; if positive, cleared by MD, Date: _____

Quantiferon-TB Gold (if applicable) { } Negative
{ } Positive: If Positive MD Counseled and Cleared Date _____

If Hepatitis B Vaccine Series is/has been given list: Date # 1 _____
Date #2 _____
Date #3 _____

Signature _____ *Date* _____
(Health Care Provider)

Hepatitis B Virus Vaccine Declination

Due to personal, medical or religious reasons, I am requesting that TRINITAS SCHOOL OF NURSING Waive the health requirement for immunization against Hepatitis B. I am aware of the health risks of this disease, the mode of transmission, and possibility of exposure to Hepatitis B to health care professionals.

Student Signature *Date*