Alfred State

State University of New York College of Technology

Nursing Department
Physical Health and Sciences Building
10 Upper College Drive, Alfred, NY 14802
607-587-3680 Fax 607-587-3684

Health History and Physical Examination Form

A physical exam must be obtained within three months of the first day of classes. A copy of the physical and immunization records must be submitted no later than two months prior to start of classes. Failure to adhere to these guidelines may result in the student's inability to attend clinical, which is a mandatory requirement of nursing course work completion.

Student Identification

Student ID#/SS# _____

Name _____
Last First MI

Home Address _____

_____

Home Phone _____ Cell Phone _____

Birthdate _____ Gender _____

Nursing Students: I hereby give permission to both Alfred State Health & Wellness Services and the Nursing Department to share pertinent health information between each other for the participation in clinical lab experience.

Student Signature: _____ Date: _____

- Physical Examination –

Name: _____ Date of Exam: _____

Height _____ Weight _____ Vision Right 20/ Corr. 20/

Blood Pressure _____/_____ Pulse _____ Left 20/ Corr. 20/

Describe any abnormalities in the space below:

	Normal	Abnormal		Normal	Abnormal
ENT			Musculoskeletal		
Respiratory			Metabolic/Endocrine		
Cardiovascular			Neuropsychiatric		
Gastrointestinal			Skin		
Genito-urinary			Other		

Mandatory Immunizations for Clinical

Varicella Vaccine				
		IMM Date 1	IMM Date 2	Date of Chicken Pox
MMR (Measles, Mumps, Rubella)				
		IMM Date 1	IMM Date 2	Titer Date
Hepatitis B (series of 3)				
	IMM Date 1	IMM Date 2	IMM Date 3	Declination Date
TDAP (Tetanus Diptheria Acellular Pertussis) Booster within the last 10 years, not to expire before the end of the clinical rotation.				
				Date
2 PPDs are required within 2 weeks of each other				
PPD – STEP 1				
		Date Given	Date Read	Result in mm
PPD – STEP 2				
		Date Given	Date Read	Result in mm
Positive PPD Chest X-Ray				
		Date of Chest X-Ray	Results	
Flu Vaccine				
			IMM Date	

I certify that the above physical examination and immunization record is accurate.

Provider Signature: _____ Date: _____

ALL IMMUNIZATION RECORDS MUST BE SIGNED BY A HEALTH CARE PROVIDER