NYC COLLEGE OF TECHNOLOGY
CITY UNIVERSITY OF NEW YORK
NURSING PROGRAM

PHYSICAL EXAMINATION FORM

NAME:			EMPLID ID:	SEMESTER:

Annual Medical Requirements for Nursing Programs within 3 months				
A.	Required blood tests (titers): ***(Copies of lab report must be attached to this form)***		If negative (not immune) indicate dates of re-vaccine (booster)	Indicate dates if repeated blood tests (titers)
	Indicate immune or not immune:		Dates of vaccination after required blood tests (titers)	Dates of blood tests after vaccination
1.	Rubeola (measles)			
2.	Mumps			
3.	Rubella			
4.	Varicella			
5.	Hepatitis B (profile)			
a.	Hep. B surface antigen			
b.	Hep. B core antibody			
c.	*Hep. B surface antibody			
d.	Hep. C (titer)			
(*Hep. B surface antibody only if you have previous Hep B Vaccine series (3 series)				
Declination Signed: (See Attached Form)			YES:	NO:
B.	Tuberculin skin test (PPD or Mantoux) within 3 months of admission to the nursing program and then it must be done yearly.			
Date:			Result:	
If TB skin test is positive either Chest X-ray or QuantiFERON Gold Plus or T-Sport Blood Test				
Date:		Result:	Date:	Result:
C.	Immunization			
1.	Tdap (Diphtheria – tetanus – pertussis booster (within 10 years)			Date
2.	Influenza Vaccine		Name of Flu Vaccine and Season:	
			Date Given:	
			Lot #:	
			Expiration Date:	
			Injection Site:	
			Provider's Name and Address	

Below Section: For Primary Care Provider Only	
Name of Provider:	Phone #:
Date Completed:	Signature:
Address:	Stamp:

(To be completed by licensed physician of health practitioner)

Height:		Vital Signs:	B.P. / mmHg
Weight:			Respiratory:
			Pulse: / Min.
Normal	Abnormal		Remarks-describe abnormalities only
		Head and Neck	
		Nose and Sinuses	
		Mouth and Throat	
		Gums and Teeth	
		eyes	
		Ears Hearing	
		Chest, Breast, Lungs	
		Heart	
		Vascular System	
		Lymphatic System	
		Abdomen and Vicera	
		Hernia	
		Anus and Rectum	
		Genito-Urinary System	
		Endocrine System	
		Spine and Musculoskeletal	
		Neurologic	
		Psychiatric	

If there is any emotional or mental condition for which the student or faculty is under observation and/or taking medication which limits their ability to function in a clinical setting involving direct patient care.	YES / NO
If yes, please explain:	
Recommendation for physical activities: full activity	YES / NO
If no, please explain:	

Name of Provider:	Phone #:
Date Completed:	Signature:
Address:	Stamp: