State University of New York
CLINTON
Community College

136 Clinton Point Drive
Plattsburgh, NY 12901

HEALTH REPORT

Nursing Students

CONFIDENTIAL

Student Name: ____

Semester and Year: ____________________________

Medical History & Physical Exam

Name: ____

Address: ____
(Street, Road, PO Box, City, State, Zip Code)

Phone: (_____) ______________________________ DOB: ____________ Age: _______ Sex: ______

Have you ever been or are you being treated for any of the following? Please check all that apply:

- ☐ Alcohol/substance abuse
- ☐ Anxiety/panic disorder
- ☐ Arthritis
- ☐ Asthma/hay fever
- ☐ Back/neck injury
- ☐ Blood disorders
- ☐ Cancer
- ☐ Chicken pox
- ☐ Convulsions/seizures
- ☐ Depression
- ☐ Diabetes
- ☐ Eating disorder
- ☐ Fainting Spells/dizziness
- ☐ Head injury/concussion
- ☐ Heart disease/murmur
- ☐ Hepatitis
- ☐ Hernia
- ☐ High blood pressure
- ☐ Inflammatory bowel syndrome
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraine headaches
- ☐ Recent weight change
- ☐ Skin disorders
- ☐ Ulcer
- ☐ Urinary tract infections
- ☐ Vision problem
- ☐ Other _______________

Medications: Please list any medication, vitamins, supplements that you take routinely. _____________
____
____

Please Answer the Following:

1. Do you have any allergies? ☐No ☐Yes If yes, please list: ______________________
____
2. Are you allergic to LATEX? ☐No ☐Yes ____
3. Would you say your present health is ☐Excellent ☐Good ☐Fair ☐Other?
If other, please explain ____
4. Have you ever had an operation? ☐No ☐Yes
If yes, please explain ____
5. Have you sustained an injury in the past six (6) months? ☐No ☐Yes
If yes, please explain ____
6. Have you ever been treated for back/neck pain or have any history of back/neck injury?
☐No ☐Yes If yes, please explain ____

I hereby certify that the answers given are true to the best of my knowledge

____ _________________________
Student Signature (parent/guardian if under 18 years of age) Date

PHYSICAL EXAM:
The exam may not be completed earlier than January 1st of the year the student is accepted into the nursing program.

Temp:	Pulse:	Respirations:
Height:	Weight:	B/P:
Vision: ☐Corrected ☐ Not Corrected	R eye:	L eye:
Hearing: R ear:	L ear:	Impairments:

Check appropriate column	Normal	Abnormal	Detail of abnormalities:
Appearance			
Ears/Nose/Throat			
Neck (Thyroid)			
Lymph Nodes			
Heart & Vascular System			
Lungs			
Abdomen			
Musculoskeletal System			
Neurological System			
Genitourinary (optional)			
Skin			

Based upon your physical examination, is the candidate able to perform the essential physically demanding job functions of a Student Nurse? ☐ Yes ☐ No

Please list and describe any accommodations required:

____

____

____

Physician/NP/PA Signature — Date of Exam

Physician/NP/PA Address & Phone Number

Hepatitis B Vaccine Waiver

In compliance with OSHA Regulation: 29 CFR BLOODBORNE PATHOGENS STANDARD 1910.1030: the student is advised that OSHA recommends persons at substantial risk for HBV (hepatitis B) should be vaccinated. Individuals are often at highest risk during the professional training period. For this reason, when possible, vaccination should be completed prior to the training period. Three injections given at 0-, 1- and 6-months must be received to complete the series.

I understand as a nursing student that I am at high risk for acquiring hepatitis B, as my clinical experience places me in a position to be exposed to a significant degree of blood and body fluids.

I acknowledge the Clinton Community College, Nursing Department, has advised me of the OSHA Regulation: 29 CFR BLOODBORNE PATHOGENS STANDARD 1910.1030.

Please check the appropriate statement:

_____ I decline hepatitis B vaccination currently. If I want to be vaccinated later, I can receive the vaccine series and I will be responsible for the cost.

_____ I am currently in the process of receiving the 3-dose series of hepatitis B vaccine. Until this process is completed, I have been informed and understand that I continue to be at risk of acquiring hepatitis B.

____
Student Name (print)

____
Student Signature

____
Date

Adapted from Occupational Safety & Health Administration
US Dept. of Labor
Standard Number: 1910.1030

_____ Initial here if you have received the series.