Original Form to be submitted to NCC Student Health Office.
Make photocopy for yourself.

Nassau Community College
Student Health Services • One Education Drive• Garden City New York 11530-6793
Phone: (516) 572-7123 • Fax: (516) 572-9637

Mortuary Science

1st Year 20_____ 2nd Year 20_____

A. **NCC-ID#:** N00_____ NAME: _____
(Print) Last First M.I.

ADDRESS: _____ _____ _____ _____
Street Address City State Zip Code

PHONE: (_____) _____ DOB: _____ Age: _____ Sex: _____

B. **PERSONAL HISTORY** - (To be filled out by student)

	Yes	No		Yes	No		Yes	No
Rheumatic Fever			Hernia			High Blood Pressure		
Heart Disease			Asthma			Seizure Disorder		
History of Tuberculosis			Kidney Disease			Speech Disorder		
⊕ Tuberculosis Skin Test			Paralysis			Allergies		
Orthopedic Problem			Sickle Cell Disease/Trait			Latex Allergy		
Diabetes			Fainting			Vision or Hearing Deficits		
Other								

List All Medications: _____

Signature: X_____

C. **CLINICAL EVALUATION** - (To be completed by healthcare provider) (No √ marks. Write Findings)

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Head		Chest-Lungs		Menses	
Skin		Heart		Cardiovascular	
Eyes		Breast		Endocrine System	
Nose		Abdomen		Lymphatic System	
Throat		Hernia		Neurological	
Teeth		Genitalia (Male)		Spine-Musculoskeletal	
Ears		Pelvic (Optional)		Lower Extremities	
Neck-Thyroid		Ano-Rectal		Upper Extremities	

Tuberculin Screening Test-one of the following to be done:
A two-step PPD or a Quantiferon/IGRA TB Gold blood test

Tuberculin Screening Test (PPD Intradermal) Two-Step (**2nd PPD to be given at least 1 week after the first PPD was planted**)
Date Given _____ Date Read (48-72HRS) _____ Result (in mm) _____
Date Given _____ Date Read (48-72HRS) _____ Result (in mm) _____

OR Quantiferon/IGRA TB Gold (attach lab copy) Date: _____ Result:_____

*History of ⊕ PPD (MANTOUX) Test: Date _____
*POSITIVE reactors to TB Test must submit written results of Chest X-ray report (PA &lateral) within two years. (Attach copy of CXR report.)
Date: _____Result:_____

Note: ALL TESTING MUST BE DONE AT TIME OF PHYSICAL. ABNORMAL RESULTS MUST BE ADDRESSED.

NCC-ID#: N_____ NAME: _____
(Print) Last First M.I.

Polio Salk-Sabin (any history) Date: _____

Tetanus/Diphtheria Booster within ten years, Date: _____

Hepatitis B Vaccine: 1st Date: _____ 2nd Date: _____ 3rd Date: _____ Titre (attach lab copy): _____

(Hepatitis B Vaccine series OR an immune Hepatitis B titer is required prior to Fall Semester of 2nd year before Embalming and Pathology).

PHYSICIAN'S CERTIFICATION:

I certify that the above named student is in reasonably good physical health to perform the duties required of a Funeral Director (Embalmer) student which may include, but is not limited to heavy lifting, maneuvering cadavers and manual dexterity.

Above named patient is deemed to be free from any addictive substances (by visual inspection only).

Is this the first time you have seen this patient? Yes_____ No_____

☐ CLEARED FOR PROGRAM ☐ NOT CLEARED FOR PROGRAM

_____

_____

_____

Physician's Signature _____ ** Date _____

Physician's Name (Print) _____ License No. _____

Physician's Stamp _____ Phone (_____) _____

Address: _____

** **DATED PHYSICAL EXAM MUST BE ON OR AFTER PPD READING DATE****