# Allied Health/Nursing Physical Form

**Nassau Community College**  
Student Health Office • One Education Drive • Garden City New York 11530-6793  
Phone: (516) 572-7123 • Fax: (516) 572-9637 • Email: healthoffice@ncc.edu

All Nursing/Allied Health students must complete this form prior to participating in clinicals.

## Allied Health/Nursing Physical Form

### Personal History

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatic Fever</td>
<td></td>
<td></td>
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<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
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<tr>
<td>Tuberculosis</td>
<td></td>
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<tr>
<td>Positive TB Skin Test</td>
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<tr>
<td>Orthopedic Problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(If none, write NONE)

**Signature:** [X]

### Clinical Evaluation

- **Height:**
- **Weight:**
- **Blood Pressure:**
- **Pulse:**

<table>
<thead>
<tr>
<th>System</th>
<th>Satisfactory</th>
<th>Un satisfactory</th>
<th>Details If Un satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Appearance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEENT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Abdomen</td>
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<td></td>
<td></td>
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<tr>
<td>Genitourinary (male)</td>
<td></td>
<td></td>
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<tr>
<td>Musculoskeletal</td>
<td></td>
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<tr>
<td>Skin</td>
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<tr>
<td>Neurovascular</td>
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<td>Endocrine</td>
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<td></td>
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<tr>
<td>Extremities</td>
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</tr>
</tbody>
</table>

**Tuberculin Screening Test:** PPD Intradermal Skin Test (If it is your FIRST PPD at NCC, it MUST be a TWO STEP PPD)

- **#1 PPD Date Given:**
- **PPD Date Read (48-72HRS):**
- **PPD Result (in mm):**

- **#2 PPD Date Given:**
- **PPD Date Read (48-72HRS):**
- **PPD Result (in mm):**

Second PPD must be given at least 1 week after the 1st PPD was planted.

**OR** QuantiFERON/IGRA blood test (attach lab copy) Date: **Result:**

**Newly Positive** PPD or QuantiFERON require CXR (attach CXR report) Date: **Result:**

**OR** History of PPD Test: Date: **Result:**

History of POSITIVE reactors to TB Test must submit Chest X-ray report within two years (attach CXR report) Date: **Result:**
NCC-ID#: N00

NAME: ____________________________

Print (Last) (First) (M.I.)

Required on Initial Physical Only:
Documentation of Immunity to Measles, Mumps, Rubella and Varicella by blood antibody testing or adequate documentation of immunizations required. **Dated original lab report MUST be attached.**

Measles/Rubeola Titer

Date: ____________ Result: ____________ OR Vaccine 1st Date: ____________ 2nd Date: ____________

Mumps Titer

Date: ____________ Result: ____________ OR Vaccine 1st Date: ____________ 2nd Date: ____________

Rubella Titer

Date: ____________ Result: ____________ OR Vaccine Date: ____________

Varicella Titer

Date: ____________ Result: ____________ OR Vaccine 1st Date: ____________ 2nd Date: ____________

Tdap or Td Booster within ten years,

Date: ____________

Hepatitis B Vaccine:
1st Date: ____________ 2nd Date: ____________ 3rd Date: ____________ or Titer: ____________

ALLIED HEALTH AND NURSING STUDENTS ARE ADVISED TO BE IMMUNIZED WITH HEPATITIS B VACCINE PRIOR TO THE BEGINNING OF CLINICAL PRACTICE OR MUST SIGN A DECLINATION STATEMENT.

DECLINATION STATEMENT

I understand that during my participation in my clinical internship, I may be exposed to blood or other potentially infectious materials and I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been informed of the need to be vaccinated with Hepatitis B vaccine. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccination, I continue to be at risk of acquiring Hepatitis B, a serious disease. I understand that Nassau Community College cannot mandate that I take this vaccination in order to continue my education in my chosen health science program. My failure to be immunized could jeopardize the successful fulfillment of the requirements of my program at Nassau Community College, which may preclude me from graduating. I further understand and agree that I cannot hold Nassau Community College responsible for any injury or illness arising from my activity and/or exposure to blood or other blood-borne pathogens in my program and clinical laboratories.

Name (Print): ____________________________

Student Signature: ____________ Date: ____________

PHYSICIAN’S CERTIFICATION:

I hereby certify that the above named person is in good health as determined by a recent physical examination of sufficient scope to ensure that he or she is free from health impairments which may be of potential risks to patients and other personnel or which may interfere with the performance of his or her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual’s behavior. This individual is able to participate in their clinical learning experiences.

Provider Please √ Check: □ CLEARED FOR PROGRAM or □ NOT CLEARED FOR PROGRAM

Physician’s Signature: ____________________________ ** Date: ____________

**Do Not Date Physical until PPD is Read

Physician’s Name (Print) ____________________________ License No. ____________

Physician’s Stamp (Required) ____________________________ Phone (______) ______

Address: ____________________________

(Rev. 3/17) (ALL INFORMATION IS CONFIDENTIAL)

***STUDENTS MUST ENSURE THEY HAVE PHOTOCOPIES OF ALL PAPERWORK BEFORE HANDING IN FOR BLUE SLIP. CLINICAL INSTRUCTORS AND FACILITIES WILL REQUIRE COPIES LATER ON. THE HEALTH OFFICE WILL NOT MAKE COPIES IF STUDENTS FAIL TO DO SO.***