Student Health Physical Examination Form

The health of the individual can affect the health of the patients in hospitals or clinics. To protect the patients from outbreaks of vaccine-preventable diseases, all students entering a health program are required to provide proof of compliance and **printout of medical history regarding** immunization with specific immunizations and tuberculosis screening. Forms must be completed and returned to Allied Health Clinical Externship Coordinator.

FULL COMPLIANCE WITH THE HEALTH REQUIREMENTS PRIOR TO CLINICAL EXPERIENCE IS MANDATORY IN ORDER FOR YOU TO SUCCESSFULLY PARTICIPATE.

Name: ____ ____________

(Last) (First) (Middle) **Please print or type**

Gender: ☐ Male ☐ Female Date of Birth: ______________________________

Address: ____

City: ________________________ State: ____________________ Zip: _____________

Home: ____________________ Cell: ____________________ Work: __________________

Student ID: ____________________ E-mail address: ______________________________

Emergency Contact: ___________________________ Relationship: _______________________

Address: ____

Home: ____________________ Cell: _______________________ Work: ___________________

Primary Physician: ____

Address: ____
Phone Number: ____

Name: ____ Program of Consideration: ___________
(Last) (First) (M.I.)

THIS FORM IS TO BE COMPLETED LEGIBLY BY A LICENSED MEDICAL PROFESSIONAL. RETURN ALL COMPLETED DOCUMENTS TO YOUR INSTRUCTOR. FAILURE TO COMPLY MAY POSTPONE CLINICAL EXPERIENCE.

PART I. MANDATORY IMMUNIZATIONS OR PROOF OF IMMUNITY:
Attach copy of immunization records if available.

A. **Measles-Mumps-Rubella (MMR) vaccine** **Month/Year**
Two (2) doses are required for students born after 1956:
Dose #1 given at 12 months after birth or later ………………………… _____/_______
Dose #2 must be at least one month after dose #1and after 1980 ……… _____/_______ Or
proof of positive immune titers (attach copy of lab report) ………… _____/_______

B. **Tetanus-Diptheria (Td) vaccine booster** **Month/Year**
Within the last ten (10) years: _____/_______

C. **FLU vaccine annually** **Month/Year**
______/_______

PART II. ANNAUAL TUBERCULOSIS (TB) SCREENING:
PPD (purified protein derivative) Mantoux skin test within 12 months prior to entry into a clinical experience. Result of PPd must be clearly stated.

- Date of PPD _______________ ☐ Negative ☐ Positive Induration size ____________ mm
- Chest x-ray is required if induration is 10 mm or grater. Date ____________ Result __________
- If PPD had been positive in the past, a chest x-ray can be done in lieu of a PPD but must be taken within 12 months prior to entry into a clinical experience. Date of Chest x-ray ___________ Result _____________

PART III. MENNINGOCOCCAL VACCINE (Recommended but not mandatory)
This vaccine is optional for your clinical experience but is strongly recommended for students entering a health care field. Date vaccine given: ______________________________

PART IV. CHICKEN POX (Attached a copy of immunization)
Dates two VZV Immunization 1) ______________________ 2) ____________________________
Date Physician diagnosed chicken pox / zoster ____
Date and result of varicella titer ____

PART V. VISUAL ACUITY RIGHT EYE ___________LEFT EYE _________________
Name: ____ Program of Consideration: ___________

PART IV. PHYSICAL EXAMINATION

A. After considering the history and physical examination, is the student able to meet the physical and emotional demands of a vocational training program which will include clinical training in a health care facility or clinic? ☐ Yes ☐ No
Comments: ____

B. Is this student able to participate in all physical activities? ☐ Yes ☐ No a). Low to high lift (11-20 lbs)
b). Carry, push pull (11-20 lbs)
c). Frequent walking, climb stairs, stoop, kneel, crouch, reaching, pushing and pulling carts

If No, what activities are restricted? ____

C. Are all New York State required immunizations up to date? ☐ Yes ☐ No

D. Has the student received the Hepatitis B Vaccine? Yes ☐ No ☐

E. Has the student been tested with a PPD within the past 12 months? ☐ Yes ☐ No

F. Annual FLU vaccine? ☐ Yes ☐ No

Name of Examining Physician ____________________________________ Date: _______________

Address: ____
(Street) (City) (State) (Zip Code)

Signature: ______________________________________ Telephone: ____________________________
Name: ____ Program of Consideration: ___________

PART V. HEPATITIS B VACCINATION

Hepatitis B Vaccine

Hepatitis B Vaccination is required for all students that may be at risk for Hepatitis B virus (HBV) exposure if tasks involve contact with blood or blood containing body fluids. I have been notified that in the course of my training I might be at increased risk of developing a disease caused by blood borne pathogens, including Hepatitis B.

Vaccination Status
Check below:

☐ Hepatitis B vaccine 3-dose program initiated or completed.
1st ________________ 2nd ______________________ 3rd __________________________

☐ Student has known immunity against the Hepatitis B virus by prior infection or by known immune antibody titer. Must attach lab report.

☐ Student understands that due to the occupational exposure to blood or potentially infectious materials he/she may be at risk of acquiring Hepatitis B virus (HBV) infection. Student has been advised by the University of Buffalo, Educational Opportunity Center to be vaccinated with the Hepatitis B vaccine. Student has chosen not to receive the Hepatitis B vaccine and fully understand the risks involved.

Student Signature: ____________________________________ Date: ________________

Witness Name: ____

Witness Signature: ____________________________________ Date: ________________

Name of Examining Physician ______________________________________ Date: ________________

Address: ____
(Street) (City) (State) (Zip Code)

Signature: ______________________________________ Telephone: ____________________________

PHYSICIAN AND OR FACILTY STAMP REQUIRED