HARTWICK COLLEGE
est. 1797

# Nursing Annual Physical Exam Record

**Returning Nursing Majors Only. Must be completed by health care provider.**
Keep a copy for your records. Questions? Call Perrella Health Center at 607-431-4120.

_____ ____/____/____ ____/____/____
Student name Date of Birth Date of Exam

## RELEASE OF INFORMATION: Must be signed by student

I hereby state that the information provided on this form is correct to the best of my knowledge. , I authorize documentation regarding my annual physical, tuberculosis screening, and immunization status to be released to the nursing department and any clinical facilities where I will be a student.

_____ ____/____/____
**Student Signature** **Date**

_____ ____/____/____
**Parent/Guardian Signature (if student is under 18 years of age)** **Date**

## ANNUAL TUBERCULOSIS TESTING

**Mantoux/TST**
Date planted: ____/____/____ Date read: ____/____/____
Results: _____ mm induration ☐ Pos. ☐ Neg.

**OR**

**Quantiferon Gold**
Result: ☐ Pos. ☐ Neg.
Copy of result must be attached.

If test is positive or a history of a positive tuberculosis screen, a *one time* chest x-ray is required.

Date of x-ray: ____/____/____ Results: _____ (attach copy) If positive test, was treatment initiated? ☐ Yes ☐ No

Medication(s): _____ Date started: ____/____/____ Date completed: ____/____/____
Per CDC guideline annual chest x-ray is NOT recommended.

Most Recent Influenza Vaccine Date: ____/____/____

## EXAMINATION **normal - X** **abnormal - explain** **OR attach data from EHR physical exam**

Vision _____

| | Corrected | Uncorrected |
|---|---|---|
| OD: | 20/____ | 20/____ |
| OS: | 20/____ | 20/____ |

Color Vision _____
Hearing _____
Test Used _____

Head _____ Eyes _____ Ears _____ Nose _____ Throat _____ Neck _____ Thyroid _____ Chest _____ Lungs _____ Extremities _____

Skin _____ Heart _____ Breast _____ Abdomen _____ Hernia _____ Genital _____ Rectal _____ Prostate _____ Pelvic _____ Back _____

Circulation _____ Neuro _____

Temp: _____ BP: _____ Pulse: _____ Resp: _____ Height: _____ Weight: _____

## STATEMENT OF FITNESS: Must be filled out and signed by health care provider

After reviewing this individual's history and completing a physical examination, I have found her/him to be in satisfactory physical condition to wear respiratory protection and care for clients unless otherwise noted below.

Limitations which prohibit the individual from providing nursing care to clients should be documented by the provider. _____

_____

_____ _____ ____/____/____
**Healthcare Provider Signature** **Phone#** **Date**