



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.

Mail to: Perrella Health Center, Hartwick College, P.O. Box 4020, Oneonta, NY 13820
Fax: 607-431-4124 | **e-mail:** healthcenter@hartwick.edu

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**

Vision _____	Head _____	Skin _____	Circulation _____
Corrected _____	Eyes _____	Heart _____	Neuro _____
Uncorrected _____	Ears _____	Breast _____	
OD: 20/ _____	Nose _____	Abdomen _____	Temp: _____
OS: 20/ _____	Throat _____	Hernia _____	BP: _____
Color Vision _____	Neck _____	Genital _____	Pulse: _____
Hearing _____	Thyroid _____	Rectal _____	Resp: _____
Test Used _____	Chest _____	Prostate _____	Height: _____
	Lungs _____	Pelvic _____	Weight: _____
	Extremities _____	Back _____	

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. _____

Fit tested for respirator use Yes No Type of respirator _____

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