DUTCHESS
COMMUNITY COLLEGE

HEALTH OFFICE

ECH/EED PHYSICAL HEALTH FORM

COMPLETED PHYSICAL MUST BE SUBMITTED ON ORIGINAL DCC FORM.
Please retain a photocopy for personal record.

Please print or type all information:

Program:_____ **A#** _____

Name:_____ **Date of Birth:**_____

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

Phone Number: _____
House **Cell**

Emergency Contact: _____
Name **Relationship** **Number**

Personal History: Please check all that apply

__ **Allergies**
__ **Asthma**
__ **Back injury/lifting restrictions/mobility restrictions**
__ **Chronic/recurrent infections/illnesses**
__ **Diabetes**
__ **Eating disorder**
__ **Heart Disease**
__ **Headache/migraines**
__ **Hearing problems**
__ **Hernia**
__ **Hypertension**
__ **Orthopedic concern**
__ **Positive TB (PPD/QuantiFERON)**
__ **Psychiatric problems**
__ **Rash/Skin disease**
__ **Seizures, dizziness, fainting**
__ **Substance use**
__ **Vision/Color Problem**
__ **Hospitalizations**
__ **Surgeries**

Explanation to above checked areas: _____

Allergies (food, medication, environmental): _____

List all medications taken regularly: _____

_____

I understand that all information and answers to questions are complete and accurate as of this date. I understand that any changes in my health status require me to contact and inform the college health office. Failure to report my current status or changes to that status may constitute suspension of my participation in the fieldwork experience until such time as I have been cleared by the college health office.

The information provided is accurate and complete to the best of my knowledge. I give permission to send this information to Dutchess Community College and to release this information to the clinical site where I am assigned.

STUDENT SIGNATURE_____ DATE _____

PARENT SIGNATURE (IF STUDENT IS UNDER 18 YEARS OF AGE)_____ DATE _____

Health Office SSB 110 53 Pendell Road Poughkeepsie NY 12601 FAX:1-888-972-1736 EMAIL: Healthoffice@sunydutchess.edu

ECH/EED PHYSICAL EXAMINATION

Be completed by MD, PA, or NP

Name_____ **A#**_____

Height:_____Weight_____BMI:_____Blood Pressure:_____Pulse: _____

Vision: Right 20/_____Left 20/_____Corrected: ☐ Hearing: Right _____Left_____Aids: ☐ Yes

Any limitations in vision/color vision Yes__ No__ Any limitations in hearing Yes __ No __

Check each item in the column, enter NE if not evaluated

	Normal	Abnormal	Notes/Details
General Appearance			
HEENT			
Cardiovascular			
Respiratory			
Abdominal			
Musculoskeletal/Spine			
Neurological/reflexes			
Skin			
OTHER			

Typical fieldwork duties

- **Lifting and carrying children**
- **Close contact with children**
- **Direct supervision of children**
- **Facility maintenance**
- **Food preparation**
- **Desk work**
- **Evacuation of children in an emergency**

To the best of my knowledge of the above-named individual, I find that:

They are currently exhibiting signs of a communicable disease that would pose a risk to the health and safety of children in care. __Y __N

They have a diagnosed psychiatric or emotional disorder that would pose a risk to the health and safety of children in care. __Y __N

They have a physical condition that would prevent them from providing typical child day care duties as described above. __Y __N

For any "YES" responses, clarify and/or indicate restrictions:

_____

_____ _____

Signature *(physician, physician assistant, nurse practitioner)* Title

_____ / / _____

Name *(please PRINT clearly or use office stamp)* Date of Exam

( ) - / / _____

Phone Date of Signature

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Immunization/Disease	Vaccine Date	Titre Date	Titre Result* Attach laboratory results
MMR	#1_____ #2 _____		
MEASLES	#1 _____ #2 _____	_____	_____
MUMPS	#1 _____ #2 _____	_____	_____
RUBELLA	#1 _____ #2 _____	_____	_____
VARICELLA	#1 _____ #2 _____	_____	_____

Disease	Vaccine Dates	Declination Date	Titre Date/ Result
Hepatitis B **Series of 3 Vaccines or Positive titre or Declination on file**	#1 _____ #2 _____ #3 _____	_____	Date: _____ Result: _____ Attach Laboratory Report

Tuberculin Testing (Quantiferon,Mantoux,PPD). With history of BCG please get Quantiferon testing.

Date Implanted:	Site implanted:	Manufacturer/Lot #/Exp. Date:
Name/Signature of person Implanting:	Name/Signature of person reading:	
Date Read:	Result in mm: _____ Induration_____Erythema_____Vesiculation: _____	
Date of Quantiferon:	Result: Attach copy of result	Positive PPD/Quantiferon Date of Chest x-ray: _____ Result: _____ Attach copy of result

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