DUTCHESS
COMMUNITY COLLEGE

HEALTH OFFICE

# PHYSICAL HEALTH FORM

**COMPLETED PHYSICAL MUST BE SUBMITTED ON ORIGINAL DCC FORM.**
**This page to be completed by student.**

**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 clinical 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 __________

# PHYSICALEXAMINATION

**To be completed by MD, PA, or NP**

**Name**______________________________________________ **A#**___________________________

Height:_________Weight__________BMI:___________Blood Pressure:_________Pulse: ___________

Vision: Right 20/_____Left 20/_____Corrected: ☐ HearingKRight _______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 duties**

- **Transfer, support and maneuver clients and objects**
- **Bend, stoop, kneel, crouch, crawl, reach and manipulate**
- **Move efficiently enough to meet the needs of clients in a timely fashion**
- **Maintain balance from any position**
- **Attend to cognitive and psychomotor tasks for extended periods of time**
- **Negotiate level surfaces, ramps and stairs**
- **Coordinate fine and gross motor movements**
- **Demonstrate emotional stability to function effectively under stress and adapt to changing environments**

**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 others. __Y __N

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

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

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

______________________________________________________________________________

To the best of my knowledge, this student is free from any health impairment which could pose a risk to patients or interfere with the performance of his/her duties.

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

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

( ) - / /
_____________________________________________ _____________________________________________
Phone Date of Signature

| 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<br>Series of 3 Vaccines or Positive titre or Declination on file | #1 ______________<br>#2 ______________<br>#3 ______________ | ______________ | Date: _____________<br>Result: _____________<br>Attach Laboratory Report |

Tuberculin Testing (PPD/Mantoux or QuantiFERON. 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: _______<br>Induration______________Erythema______________Vesiculation: _______________ |
| --- | --- |

| Date of Quantiferon: | Result:<br><br>Attach copy of result | Positive PPD/Quantiferon __<br>Date of Chest x-ray: __________ Result: ________________<br>Attach copy of result |
| --- | --- | --- |