DUTCHESS
COMMUNITY COLLEGE

HEALTH OFFICE

HEALTH REPORT AND PHYSICIAN'S CERTIFICATE

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 boxes that apply

- ☐ Vision Problems
- ☐ Speech Disorder
- ☐ Epilepsy
- ☐ Allergic Rhinitis
- ☐ Asthma
- ☐ Tuberculosis
- ☐ BCG history
- ☐ Positive TB skin test (PPD Quantiferon)
- ☐ Fever
- ☐ Weight Gain/Loss
- ☐ Fatigue
- ☐ Fainting
- ☐ Thyroid Disease
- ☐ Kidney disease
- ☐ Diabetes

- ☐ Sexually transmitted disease
- ☐ Hepatitis
- ☐ Skin Disease
- ☐ Rash
- ☐ Headache
- ☐ Hernia

- ☐ Orthopedic Problem
- ☐ Arthritis
- ☐ Back injury
- ☐ Neck/back pain
- ☐ Joint Pain

- ☐ Intestinal Disorder
- ☐ Gastritis
- ☐ Loss of Appetite
- ☐ Nausea
- ☐ Heartburn
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation

- ☐ Heart disease
- ☐ Hypertension
- ☐ Shortness of breath
- ☐ Cough/wheeze
- ☐ Chest pains
- ☐ Palpitations

- ☐ Psychiatric Problems
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

- ☐ Hospitalization
- ☐ Surgeries

Habits (times per day)

Caffeine: ____________

Smoking: ____________

Alcohol: ____________

Exercise: ____________

Allergies (food, medication, environmental): ________________________________

List all medications taken regularly: ________________________________

Explanation to above checked areas: ________________________________

____

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 __________

Name ____________________ A#____________________

To be completed by Health Care Professional

Immunization/Disease	Vaccine Date	Titre Date	Titre Result* Attach all laboratory records
MMR	#1 ______ #2 ______		
MEASLES	#1 ______ #2 ______	______	______
MUMPS	#1 ______ #2 ______	______	______
RUBELLA	#1 ______ #2 ______	______	______
VARICELLA	#1 ______ #2 ______	______	______

**All equivocal titre results require an additional vaccine.

Disease	Immunization Dates	Declination Date	Date of Titre/Result
HEPATITIS B Series of 3 vaccines or Positive titre or Declination on file	#1 ______ #2 ______ #3 ______	______	______ Laboratory report needs to be attached

IGRA/QUANTIFERON (PPD NOT ACCEPTABLE)

Must be completed between JUNE 15, 2021 thru September 15, 2021

Date ____________________ Result: ____________________ Attach copy of result

Positive IGRA/Quantiferon

Date of Chest xray: ____________________ Result: ____________________ Attach copy of xray report

PHYSICAL EXAMINATION

Be completed by MD, PA, or NP

RN signature not acceptable

Name____ **A#**___________________________

Height: ________ Weight ________ BMI: ________ Blood Pressure: _______ Pulse: __________

Vision: Right 20/_____ Left 20/_____ Corrected: ☐ Yes ☐ No Hearing: Right _______ Left _______ Aids: ☐ Yes

Date of Exam: ____________

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

	Normal	Abnormal	Notes/Details
Head/Neck/Scalp/Face			
Nose and Sinuses			
Mouth and Throat			
Teeth and gingival			
Ears			
Eyes (lids,conjunctiva, pupils etc.)			
Chest and Lungs			
Heart			
Vascular system (varicosities)			
Abdomen and viscera(hernia)			
Spine and Musculoskeletal			
Neurological			
Genitourinary System			
Anorectal			
Upper and lower extremities			
Skin and lymphatics			
Endocrine			

Urinalysis:	**Glucose**	**Bilirubin**	**Ketones**	**Specific Gravity**	**Blood**	**PH**	**Protein**	**Nitrites**	**Leukocytes**

Hemoglobin: __________ **Hematocrit:** __________

Has patient been treated for psychological problems, substance abuse, or eating disorders? ☐ Yes ☐ No

If yes, please describe:____

Technical standards: Does this student have?

Any limitations in visual acuity ☐ Yes ☐ No

Any limitations in hearing ability ☐ Yes ☐ No

Any limitations in physical endurance ☐ Yes ☐ No

Any limitations in communication ☐ Yes ☐ No

Any limitations in tactile ability ☐ Yes ☐ No

Any limitations in fine motor skills ☐ Yes ☐ No

Any limitations in strength and mobility ☐ Yes ☐ No

Any limitations in emotional stability ☐ Yes ☐ No

Is there any reason this person should not participate in a rigorous nursing program? ☐ Yes ☐ No

Please describe any yes answers:____

____

Signature of Health Care Provider:____

Address:____ **Date of Exam:**_________________________

Phone: ______________________ **Fax:** ____________________ **Date Signed:**_________________________