Harriet Rothkopf Heilbrunn School of Nursing

Clinical Affiliation & Physical Examination Form

Faculty Type: Adjunct__ Full Time___

Class You Are Teaching: N190___ N290___ N390___ N490___ Grad___

FACULTY NAME (Last, First) _____ DOB SEX EMAIL - LIU

HOME ADDRESS (Number & Street) CITY or TOWN STATE/COUNTRY ZIP

HOME NO. CELL NO. EMERGENCY CONTACT NO.

To be completed by FACULTY: PERSONAL HISTORY **[Faculty: Please complete this page before going to your provider for examination]**

HAVE YOU HAD:	**YES**	**NO**		**YES**	**NO**
Scarlet Fever			Tumor		
Measles			Cancer		
German Measles			Cyst		
Mumps			Jaundice		
Chicken Pox			Stomach Trouble		
Malaria			Intestinal Trouble		
Gum Trouble			Insomnia		
Tooth Trouble			Frequent Anxiety		
Sinusitis			Frequent Depression		
Eye Trouble			Worry or Nervousness		
Ear Trouble			Recurrent Headaches		
Nose Trouble			Recent Colds		
			Head injury with Unconsciousness		
Surgery			Hay Fever		
Appendectomy			Asthma		
Tonsillectomy			Tuberculosis		
Hernia Repair			Shortness of Breath		
Other					
Chest Pain			**Allergy**		
Chest Pressure			Penicillin		
Chronic Cough			Sulfonamides		
Palpitations (Heart)			Serum		
High Blood Pressure			Foods (which)		
Low Blood Pressure			Other		
Rheumatic Fever			Gallbladder Trouble		
Heart Murmur			Or Gallstones		
Joint Problems:			Recurrent Diarrhea		
Trick Knee			Hernia		
Should			Recent Weight		
Back Problems			☐ Gain ☐ Loss		
Diabetes			☐ Dizziness ☐ Fainting		
Hypoglycemia			☐ Weakness ☐ Paralysis		
			☐ Epilepsy ☐ Convulsions		
			Smoker – How many per day		

FACULTY AFFIDAVIT: I hereby certify that all information entered is complete and accurate.

Faculty Signature_____ **Date**_____

Faculty Name:_____

To be completed by PROVIDER:

[Providers: Please fill-in all information, only attach requested items]

IMMUNIZATIONS and TESTS – Please give complete dates (Month/Day/Year)

	Numeric Titer Result	Date *(BOOSTERS ONLY)*	Labs/Proof Attached
Rubeola (Measles)			LAB REPORT **MUST** BE ATTACHED
Mumps			LAB REPORT **MUST** BE ATTACHED
Rubella			LAB REPORT **MUST** BE ATTACHED
Varicella			LAB REPORT **MUST** BE ATTACHED
HEP B Surface AB Titer			LAB REPORT **MUST** BE ATTACHED
HEP C Titer			LAB REPORT **MUST** BE ATTACHED
TDap			
Flu Vaccine (required)	**Date:**	**Exp:**	**LOT#**

I HAVE EXAMINED THE FOLLOWING: (Must be completed by Physician)

	FINDINGS:
1.Head, Eyes, Ears, Nose, & Throat	
2. Respiratory	
3. Cardiovascular	
4. Gastrointestinal	
5. Genitourinary	
6. Musculoskeletal	
7. Neuropsychiatric	
8. Skin	

TUBERCULOSIS SCREENINGS (must be one of the following):

Quantiferon Gold	ATTACH LAB REPORT
Tuberculin Skin Test (TST) **2 step PPD required OR two years of PPD results OR Quantiferon Gold**	**Step 1** Date Administered: _____ Date Read: _____ Results: ___ mm TST Read by: _____ **Step 2** Date Administered: _____ Date Read: _____ Results: ___ mm TST Read by: _____

If TST/Mantoux is positive, subsequent chest x-ray is required and annual TB Questionnaire must be completed.

CXR Date: _____ Results: _____

Has medication be prescribed? _____

Medication: _____

Duration: _____

This section must be completed

Height _____ Weight _____ Blood Pressure _____

Please check one of the following:

_____ May participate in clinical experiences in healthcare agencies and organizations and is free from any health impairment which is of potential risk to patients or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

_____ Must be restricted or adaptive program designed for her/his physical limitations. Indicate specific limits: _____

_____ Should not participate in clinical experiences

Providers Signature: _____ License #_____

Print Name: _____

Address: _____

_____

Date: _____

Stamp