



# 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		
<b>Surgery</b>			Hay Fever		
Appendectomy			Asthma		
Tonsillectomy			Tuberculosis		
Hernia Repair			Shortness of Breath		
Other					
Chest Pain			<b>Allergy</b>		
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			<input type="checkbox"/> Gain <input type="checkbox"/> Loss		
Diabetes			<input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting		
Hypoglycemia			<input type="checkbox"/> Weakness <input type="checkbox"/> Paralysis		
			<input type="checkbox"/> Epilepsy <input type="checkbox"/> 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)

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

**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) <b>2 step PPD required OR two years of PPD results OR Quantiferon Gold</b>	<b>Step 1</b>	<b>Step 2</b>
	Date Administered: _____	Date Administered: _____
	Date Read: _____ Results: ___ mm	Date Read: _____ Results: ___ mm
	TST Read by: _____	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: \_\_\_\_\_

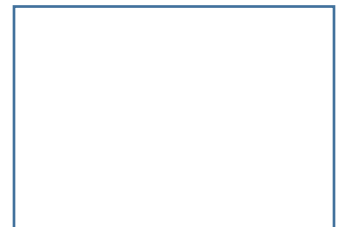
\_\_\_\_\_ Should not participate in clinical experiences

Providers Signature: \_\_\_\_\_ License # \_\_\_\_\_

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_



Stamp