MARIA COLLEGE

PHYSICAL EXAMINATION FORM

700 New Scotland Avenue, Albany, New York 12208 • www.mariacollege.edu

TO THE STUDENT: For participation in the Nursing and the Occupational Therapy Assistant programs, this Physical Examination Form MUST be completed in its entirety, properly signed (see reverse), and then scanned and uploaded to your CastleBranch account. FAILURE TO COMPLETE AND SUBMIT THIS PHYSICAL EXAMINATION FORM WILL PROHIBIT STUDENT'S PARTICIPATION IN PROGRAM CLINICAL OR FIELD EXPERIENCES.

STUDENT INFORMATION

Degree/Certificate Program: _____
(Note: Nursing Students, Please specify PNC, ADN or Bachelors Program)

Name: _____ Date of Birth: _____
Last / First / Middle

Address: _____
Street / City / State / Zip

Email: _____ Phone: (___) _____ Cell: (___) _____

Emergency Contact Name/Address: _____

_____ Phone: (___) _____

TO THE PHYSICIAN: Physical examination and laboratory tests must cover the academic year (August through May of the following year). Information provided is confidential. (SEE REVERSE)

PHYSICAL EXAM INFORMATION

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

General Appearance (Explain): _____

Urinalysis (Optional): ❑ Normal ❑ Other (Explain): _____ Date: ___/___/___

Blood Work–CBC (Optional): ❑ Normal ❑ Other (Explain): _____ Date: ___/___/___

Systems:

Skin & Lymphatic	❑ Normal	❑ Abnormal	Lungs, Chest	❑ Normal	❑ Abnormal
Head, Face, Neck	❑ Normal	❑ Abnormal	Heart	❑ Normal	❑ Abnormal
Nose & Sinuses	❑ Normal	❑ Abnormal	Vascular System	❑ Normal	❑ Abnormal
Mouth & Throat	❑ Normal	❑ Abnormal	Abdomen & Viscera	❑ Normal	❑ Abnormal
Teeth & Gingiva	❑ Normal	❑ Abnormal	Endocrine System	❑ Normal	❑ Abnormal
Ears	❑ Normal		Spine	❑ Normal	❑ Abnormal
Canals: R ____ L ____		TM's _____	Neurologic	❑ Normal	❑ Abnormal
Whispered Voices: R ____ L ____			Musculoskeletal	❑ Normal	❑ Abnormal
Eyes R L					
With glasses R ____ L ____					

Explain all abnormalities noted above: _____

The patient is under treatment for the following medical conditions: _____

Please itemize all prescription medications patient is taking: _____

Recommendation for physical activity: ❑ Unlimited ❑ Limited. Explain: _____

List all allergies patient has: ❑ Bees/Insects Carry an EPI-PEN: ❑ Yes ❑ No

❑ Environmental: _____ ❑ Medications: _____

❑ Foods: _____ ❑ Latex: _____

❑ Other: _____

continued on reverse

IMMUNIZATION RECORD

THIS SECTION MUST BE COMPLETED FOR ALLIED HEALTH (NURSING AND OCCUPATIONAL THERAPY ASSISTANT) PER CLINICAL AGENCY REQUIREMENTS.

NOTE: Public Health Law 2165 now requires post-secondary students to show protection against measles, mumps, and rubella. While persons born prior to January 1, 1957 are exempt from this requirement for the College, this exemption does not apply to clinical placements in the Nursing and Occupational Therapy Assistant programs.

Please complete chart by indicating dates in the appropriate boxes.			**Titer** *(only complete if you do not know vaccine dates.)*		
Vaccine	**Disease**	**Vaccine Date**	**Titer Date**	**Titer Results** *Immune*	*Not Immune*
Combined as MMR *Must be after 1972*		1. ___/___/___ 2. ___/___/___		❑	❑
Measles (Rubeola) *Two required must be after 1968*		1. ___/___/___ 2. ___/___/___		❑	❑
Rubella *Must be after 1969*				❑	❑
Mumps *Must be after 1969*				❑	❑
Varicella *(Immunity to Chicken Pox)*		1. ___/___/___ 2. ___/___/___		❑	❑
Hepatitis B *Or declination/waiver is required*		1. ___/___/___ 2. ___/___/___ 3. ___/___/___		❑	❑
Meningitis *Within the past 10 years or declination/waiver is required*				❑	❑
Tdap *Initial vaccination*				❑	❑
Td or Tdap Booster *Must be within 10 years*				❑	❑

Annual Tuberculosis Screening

Note: Two PPD tests are now required; a minimum of 21 days (three weeks) apart AND no longer than one year apart.

First Mantoux (PPD) *Date Administered:* _____ *Date Read:* _____ *Result:* ❑ *Negative* ❑ *Positive**

Second Mantoux (PPD) *Date Administered:* _____ *Date Read:* _____ *Result:* ❑ *Negative* ❑ *Positive**

**If PPD result is positive:*

Chest X-ray *Date of X-ray:* _____ *Results:* _____

PROVIDER: Please sign, date and return this form to patient/student.

Physician, PA or NP Signature: _____

Print Last Name: _____

License #: _____ *Phone:* _(____)_____ *Date:*___/_____

STUDENT: Please review, sign, and date this form.

Student Signature: _____

Print Last Name: _____ *Phone:* (___) _____ *Date:*___/___/___

Nondiscrimination Policy: Maria College is a nonprofit, independent, coeducational institution, which does not discriminate in its enrollment or employment practices for any reason, including race, sex, color, national origin, creed, sexual orientation, or mental or physical disability. Information about the services, activities and facilities accessible to the disabled may be obtained in the Office of Student Support, Mercy Hall. For further information regarding Title IX and 504, contact Andrew Ledoux, Title IX Coordinator, 518.861.2505.