

**Return To:**  
 Clinical Site Coordinator  
 Decker School of Nursing  
 PO Box 6000  
 Binghamton, NY 13902-6000  
 (607) 777-4845  
 Fax: (607) 777-4440



**For Office Use Only:**  
 Received \_\_\_\_\_  
 Reviewed \_\_\_\_\_  
 Approved \_\_\_\_\_

### Student Annual Health Evaluation 2008-2009

The New York State Department of Health Regulation Section 405.3 (b) (10) mandates physical examinations and annual reassessments for all persons who have patient contact. The Decker School of Nursing has formal contracts for student clinical experiences with health care agencies who must comply with this Department of Health regulation. Because students who participate in clinical experiences will have patient contact, all students in the Decker School of Nursing are required to submit the Student Annual Health Evaluation. Students may need to meet additional clinical agency requirements to be eligible to participate in clinical experiences in those settings

Name \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 (LAST) (FIRST) (MI) (M/D/Y)

Home Address \_\_\_\_\_ Home Telephone (\_\_\_\_\_) \_\_\_\_\_  
 (CITY) (STATE) (ZIP)

Local Address \_\_\_\_\_ Local Telephone (\_\_\_\_\_) \_\_\_\_\_  
 (CITY) (STATE) (ZIP)

**Student Health History:** To be completed by the student **BEFORE** the physical examination.

1. Family History: Please complete by providing the information requested below.

	Age	Health Status	Occupation	Living	Age at Death	Cause of Death
<b>Father</b>						
<b>Mother</b>						
<b>Brothers</b>						
<b>Sisters</b>						

Have any of your relatives ever had any of the following?

	Yes	No	Relationship		Yes	No	Relationship
Arthritis				Heart Disease			
Asthma and/or Hay Fever				High Blood Pressure			
Cancer				Kidney Stones			
Diabetes				Stomach/Intestinal Disease			
Epilepsy or Convulsions				Tuberculosis			

2. Personal History: Please answer all questions. **COMMENT ON ALL POSITIVE ANSWERS IN THE SPACE BELOW.**

	Yes	No		Yes	No		Yes	No
Allergy:			Emotional Problems:			Seizure Disorder		
Penicillin			Anxiety (frequent)					
Sulfonamides			Depression (frequent)			Sexually Transmitted Disease		
Serum			Insomnia					
Food (specify)						Shortness of Breath		
			Eye Problems					
Other						Stomach or Intestinal Trouble		
			Gallbladder/Gallstone Trouble					
Chest Pain/Pressure						Surgery (specify):		
			Hayfever					
Communicable Diseases:								
Chicken Pox			Head Injury with Unconsciousness					
Measles (Rubeola)								
Mumps			Headaches (frequent)					
Rubella (German Measles)						Tumor, Cancer, Cyst		
Malaria			Heart Disease or Rheumatic Fever					
Scarlet Fever						Urinary Tract Problems:		
Tuberculosis			Heart Palpitations			Albumin/Sugar		
						Frequent Urination		
Dental Problems			Hernia Rupture			Other		
Diabetes			High Blood Pressure			Weakness, Paralysis		
Diarrhea (recurrent)			Jaundice			Weight Gain or Loss (recent)		
Disease or Injury of Joints, Back			Mononucleosis			<b>Females Only:</b>		
						Excessive Flow		
Dizziness, Fainting			Respiratory Problems			Irregular Flow		
			Asthma			Severe Cramps		
			Cough (chronic)					
			Ear, Nose, Throat Trouble					
			Sinusitis					

**COMMENTS FOR PERSONAL HISTORY:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

	Yes	No
Has your physical activity been restricted during the past five years? Please give reasons and details.		
Have you received treatment or counseling for mental or emotional problems, an eating disorder, or a substance use problem?		
Have you had an illness or injury or been hospitalized other than already described? Please give details.		
Other than routine checkups, have you consulted or been treated by clinics, nurse practitioners, physicians, or other practitioners within the past five years? Please give details.		

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

DECKER SCHOOL OF NURSING IMMUNIZATION RECORD 2008-2009

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**MENINGITIS: ALL STUDENTS MUST COMPLETE THIS SECTION** Please check one:

I have (or for students under 18, My child has)

\_\_\_\_\_ had the meningococcal immunization (Menomune/Menactra) within the past 10 years: Date \_\_\_\_\_

\_\_\_\_\_ read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will NOT obtain immunization against meningococcal meningitis disease. I understand that I may choose to seek vaccination in the future. The vaccine is available at the University Health Service for a fee and may also be available from community health providers or county health departments.

\_\_\_\_\_  
Signature of Student (or Parent/Guardian if under 18) \_\_\_\_\_ Date

**1. Required: Diphtheria/Tetanus Immunity** - Must have both of the following:

A. Dates of Diphtheria/Tetanus Series: \_\_\_\_\_ And  
Dose 1      Dose 2      Dose 3      Dose 4      Dose 5

B. Date of last combination Tetanus Toxoid and Diphtheria Toxoid or Tdap \_\_\_\_\_.  
Must be given within the past ten years.

**2. Required: Polio Immunity**- Must have the following:

A. Dates of Polio Series: \_\_\_\_\_  
Dose 1      Dose 2      Dose 3      Dose 4

**3. Required: Measles (Rubeola) Titer Documenting Immunity**

A. Date of Measles Titer \_\_\_\_\_ and results \_\_\_\_\_. A copy of the Measles Titer Report must be attached to this form.

**4. Required: Mumps Titer Documenting Immunity**

A. Date of Mumps Titer \_\_\_\_\_ and results \_\_\_\_\_. A copy of the Mumps Titer Report must be attached to this form.

**5. Required: Rubella (German Measles) Titer Documenting Immunity**

A. Date of Rubella Titer \_\_\_\_\_ and results \_\_\_\_\_. A copy of the Rubella Titer Report must be attached to this form.

**6. Required: Chickenpox Immunity** - Must have one of the following:

A. Date of Varicella-Zoster Titer \_\_\_\_\_ and results \_\_\_\_\_. A copy of the Varicella-Zoster Titer Report must be attached to this form. Or

B. Dates for two doses of Varicella vaccine (1) \_\_\_\_\_ and (2) \_\_\_\_\_. The two doses should be given 4 to 8 weeks apart.

**7. Required: Hepatitis B Immunity** - Must have both of the following:

A. Dates for Hepatitis B Series: \_\_\_\_\_  
Dose 1      Dose 2      Dose 3

The second and third dose should be administered not less than 1 and 6 months, respectively, after the first dose. And

B. Date of Hepatitis B Surface Antibody Titer \_\_\_\_\_ and results \_\_\_\_\_. A copy of the Hepatitis B Titer Report must be attached to this form. The post-vaccination titer should be obtained between 1 and 6 months or after following completion of the series.

Signature of NP/PA/Physician \_\_\_\_\_ Date \_\_\_\_\_  
(Acknowledging review of STUDENT IMMUNIZATION RECORD)

**BINGHAMTON UNIVERSITY - Decker School of Nursing  
STUDENT HEALTH HISTORY AND PHYSICAL EXAMINATION 2008-2009**

Name \_\_\_\_\_ Date of Exam \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

**Past History**

Medical	Allergies
Surgical	Medications
Family History	
Review of Systems	Habits

Hemoglobin and/or Hematocrit: Hgb \_\_\_\_\_ Hct \_\_\_\_\_ Urinalysis Sugar \_\_\_\_\_ Albumin \_\_\_\_\_  
 (Optional) (Optional)

Intradermal Mantoux Tuberculin Test. Required even if BCG vaccine received. Administered on or after May 8, 2008 for the 2008-09 academic year. 1. Date administered: _____ Date read: _____ MM Induration: _____ Signature of Health Care Provider: _____ <b>AND</b> 2. Date administered: _____ Date read: _____ MM Induration: _____ Signature of Health Care Provider: _____ <b>OR</b> PPD within the past year Date administered: _____ Date read: _____ MM Induration: _____ Signature of Health Care Provider: _____  If positive, chest x-ray is <u>required</u> . Chest X-ray Date _____ Result _____	
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Please note any abnormalities of the following systems by checking the appropriate column and describe completely under comments.

	WNL	ABN	Comments
1. Head/Neck			
2. Eyes/Ears/Nose/Throat			
3. Skin			
4. Lungs			
5. Heart			
6. Breasts			
7. Abdomen			
8. Rectal			
9. Pelvic			
10. Extremities			
11. Neuro			
12. Musculoskeletal			
13. Metabolic/Endocrine			

14. Is the patient currently under treatment for any physical or emotional condition? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain.

15. Are there any restrictions on physical activity? Yes \_\_\_\_\_ No \_\_\_\_\_ . If yes, please explain

16. Do you have any other comments and/or recommendations? Yes \_\_\_\_\_ No \_\_\_\_\_ . If yes, please explain.

I have determined that \_\_\_\_\_ is free from any health impairment which is of potential risk to patients or which might interfere with the performance of her/his duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or "substances" which might alter the individual's behavior.

**Signature of Examining NP/PA/Physician** \_\_\_\_\_ License/Certification No \_\_\_\_\_

Name and Title of Nurse Practitioner/Physician (Please Print or Type) \_\_\_\_\_

Address \_\_\_\_\_  
 (STREET) (CITY) (STATE) (ZIP)

Telephone (\_\_\_\_\_) \_\_\_\_\_ Date \_\_\_\_\_