DUE DATE

_____

ADMISSION PHYSICAL ASSESSMENT FORM

PLEASE PRINT

LAST NAME _____ **FIRST NAME** _____

DATE OF BIRTH _____ **PHONE** _____

ADDRESS_____

CITY_____ **STATE**_____ **ZIP CODE**_____

HISTORY AND REVIEW OF SYSTEMS

Completed by Physician or Nurse Practitioner

Date of Physical Exam_____

Head/Neck: _____ Skin: _____

Respiratory: _____ ENT: _____

Neurological: _____ Endocrine: _____

GI/Abdomen: _____ Cardio-Vascular: _____

Muscular/Skeletal: _____ Medications: _____

Allergies: _____

Past Illnesses/Injuries: _____

Current Illnesses/Injuries: _____

Smoking: Yes: _____ No: _____ How Often? _____

Alcohol: Yes: _____ No: _____ How Often? _____

Drugs: Yes: _____ No: _____ How Often? _____

HT: _____ WT: _____ BP: _____ P: _____ R: _____ T: _____

Comments: _____

ALL TITERS AND LAB REPORTS MUST BE COPIED AND ACCOMPANY THIS FORM. PLEASE SUBMIT 3 SET OF COPIES -- MEDICAL FORMS AND LAB REPORTS.

NAME: _____

CBC
Document of results of laboratory studies (include laboratory report).

Component	Results
Hemoglobin (Hgb)	
Hematocrit (Hct)	
Red blood cell count (RBC)	
Platelets	
White blood cell count (WBC)	

URINE TOXICOLOGY

A 10-panel urine **(chain of command)** toxicology must be performed. The healthcare provider may have to provide a referral for this to be done in a laboratory that provides this service. Please note that some facilities do not accept urine toxicology tests that do not follow this format (include laboratory report).

Test	Results
10-panel Urine Toxicology	

Comments: _____

_____

_____

_____

_____

_____

NAME: _____

IMMUNIZATIONS

MEASLES, MUMPS, RUBELLA

Document administration of two doses of MMR vaccine or laboratory evidence of immunity will be required (include laboratory report)

Immunization	Date
MMR# 1	
MMR#2	

MMR IGG Titer	Date	Results
Rubeola/Measles		
Mumps		
Rubella/German Measles		

VARICELLA (CHICKEN POX)

Document administration of two doses of varicella vaccine or laboratory evidence of immunity (include laboratory report)

Immunization	Date
Varicella vaccine # 1	
Varicella vaccine #2	

IGG Titer	Date	Results
Varicella		

INFLUENZA

Document administration of annual influenza (flu) vaccine.

Date of Influenza (flu) vaccine	
Manufacturer	
Lot #	
Route	
Signature	

NAME: _____

TETANUS, DIPTHERIA, PERTUSSIS
Document administration of Tdap vaccine within the past 10 years.

Date of Tdap vaccine: _____

HEPATITIS B

Document completed Hepatitis B vaccine series or positive titer or a signed declination is required (include laboratory report)

Immunization	Date
Hepatitis B vaccine # 1	
Hepatitis B vaccine #2	
Hepatitis B vaccine #3	

Titer	Date	Results
Hepatitis B Surface Antibody Titer		

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DECLINATION STATEMENT

If Hepatitis B titer is negative:

I understand that due to my exposure to potentially infections materials in clinical arrears, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have declined Hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B.

_____ _____
SIGNATURE DATE

THIS SECTION IS TO BE COMPLETED AND SIGNED BY STUDENT
MENINGOCOCCAL (One dose within 10 years recommended by NYS PHL § 2167)
See fact sheet (Page 8)
CHECK ONE (1) BOX ONLY

- ❑ Quadrivalent polysaccharide vaccine (MenomoneTH) within the past 10 years.

  Date received_____

- ❑ I Have read, or have had explained to me, the information regarding meningococcal meningitis disease. I will obtain immunization against meningococcal meningitis **within 30 days** from my private health care provider.

- ❑ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risk of not receiving the vaccine. I have decided that I will **not** obtain immunization against meningococcal meningitis disease.

Student Signature: _____ Date: _____

NAME: _____

Tuberculosis

All new students, regardless of the current risk classification, should receive baseline Tuberculosis screening using two–step Tuberculin Skin Test (TST) or a single Quantiferon gold (QFT) to test for infection with *M. tuberculosis within the last 6 months.*

If a PPD is administered, the first TST is to be administered and read within 48 to 72 hours.

If the first-step TST result is negative, the second-step TST should be administered 14 days after the first TST result is read. Two consecutive PPDs are required.

Individuals with a documented positive Tuberculin Skin Test (TST), or documented positive QFT will be exempt from the Tuberculin Skin Testing or an additional QFT. A current chest x-ray within 12 months is required to confirm no active disease.

First-Step Tuberculin Skin Test (TST)

Date Administered_____

Administered by_____
(Name and Title of Healthcare Provider)

Location

_____Left Forearm _____Right Forearm

Lot #: _____ Manufacturer: _____ Expiration Date: _____

Results

_____Negative _____ Positive _____MM Induration

Date: _____

Read by: _____
Name and Title of Healthcare Provider

License #: _____

NAME: _____

If negative, repeat Mantoux test after 14 days

Tuberculosis

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Second-Step Tuberculin Skin Test (TST) *administered 14 days after the first negative TST result is read*

Date Administered_____

Administered by_____
(Name and Title of Healthcare Provider)

Location

_____Left Forearm _____Right Forearm

Lot #: _____ Manufacturer: _____ Expiration Date: _____

Results

_____Negative _____ Positive _____MM Induration

Date: _____

Read by: _____
Name and Title of Healthcare Provider

License #: _____

NAME: _____

ATTESTATION

Positive TST

I attest that the applicant _____ has a documented positive Tuberculin Skin Test (TST), or documented positive QFT, and is exempt from the Tuberculin Skin Testing or an additional QFT. The applicant is free of symptoms of tuberculosis. A current chest x-ray within the last 12 months is being submitted to confirm no active disease.

In compliance with the New York Health Code, I have examined the above applicant. He/she **(IS, IS NOT)** (circle one) physically and mentally capable of performing the functions of a nursing student, and **(IS, IS NOT)** (circle one) free from any condition or communicable disease which would endanger his/her safety or the safety and well-being of the patient/client/resident to be cared for.

I attest that the above information is true.

Medical Provider Name: _____

Medical Provider Signature: _____

Address: _____

Phone: _____

Office stamp

Date:

MENINGOCOCCAL DISEASE FACT SHEET

New York State Department of Health – Bureau of Communicable Disease Control

What is meningococcal disease?
Meningococcal disease is a severe bacterial infection of the bloodstream or meninges (a thin lining covering the brain and spinal cord).

Who gets meningococcal disease?
Anyone can get meningococcal disease, but it is more common in infants and children. For some college students, such as freshmen living in dormitories, there is an increased risk of meningococcal disease. Between 100 and 125 cases of meningococcal disease occur on college campuses every year in the United States; between 5 and 15 college students die each year as result of infection. Currently, no data are available regarding whether children at overnight camps or residential schools are at the same increased risk for disease. However, these children can be in settings similar to college freshmen living in dormitories. Other persons at increased risk include household contacts of a person known to have had this disease, and people traveling to parts of the world where meningitis is prevalent.

How is the germ meningococcus spread?
The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person. Many people carry this particular germ in their nose and throat without any signs of illness, while others may develop serious symptoms.

What are the symptoms?
High fever, headache, vomiting, stiff neck and a rash are symptoms of meningococcal disease. Among people who develop meningococcal disease, 10-15% dies, in spite of treatment with antibiotics. Of those who live, permanent brain damage, hearing loss, kidney failure, loss of arms or legs, or chronic nervous system problems can occur.

How soon do the symptoms appear?
The symptoms may appear two to 10 days after exposure, but usually within five days.

What is the treatment for meningococcal disease?
Antibiotics, such as penicillin G or ceftriaxone, can be used to treat people with meningococcal disease.

Is there a vaccine to prevent meningococcal meningitis?
Yes, a safe and effective vaccine is available. The vaccine is 85% to 100% effective in preventing four kinds of bacteria (serogroups A, C, Y, W-135) that cause about 70% of the disease in the United States. The vaccine is safe, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to 2 days. After vaccination, immunity develops within 7 to 10 days and remains effective for approximately 3 to 5 years. As with any vaccine, vaccination against meningitis may not protect 100% of all susceptible individuals.

How do I get more information about meningococcal disease and vaccination?
Contact your family physician or your student health service. Additional information is also available on the websites of the New York State Department of Health, www.health.state.ny.us; the Centers for Disease Control and Prevention www.cdc.gov, and the American College Health Association, www.acha.org.