Program Name: **Adult Practical Nurse**

Physical Examination required for **Practical Nurse** Students.
Please answer all questions on both sides.

Student Name: _____ DOB: _____

**Directions: Please put an ☒ or ☑ in the appropriate box below. If dates or explanations are required, please supply as indicated.
****Failure to complete this form in its entirety will prevent the student from participating in the clinical and possibly the lab portions of their program.****

Exam Date_____ A physical exam was performed on the above named student on the date indicated.

Diagnostic Impression:

☐ **May** participate ***WITHOUT*** restrictions in the clinical lab and clinical portion of program

☐ Restrictions apply: List of restrictions: _____

☐ **No pre-existing conditions**

☐ Pre-existing conditions: (please list) _____

IMMUNIZATION RECORD for adults over age 18-Public Health Law # 2165 (Adult Student), Secondary Students must comply with Public Health Law # 2164. See your School District Health Office for a copy of your record

1. **SEASONAL FLU VACCINE** (Current Year Oct–Dec) or waiver.

   Date given:_____ ☐ Waiver: NYSDOH waiver must be attached

2. **ANNUAL PPD: Initial is:** 2-step Tuberculin Screenings, chest X-ray or annual QuantiFERON-TB Gold blood test may be performed to meet this requirement.

THE PPD(s) MUST BE WITHIN A YEAR TO BE VALID

**(Mantoux method only) prior to entry to class

NYSDOH *- Recommendation for the Management of Communicable Diseases among Employees in Health Care Facilities (H-28, RHCF-16, D&TC-17)*

- *Procedure for Two-Step PPD(administration directions)*
  - *persons whose initial TST (tuberculin skin test) result is negative are given a second TST* ***administered 1-3 weeks after the first TST*** *was placed and* ***read 48 to 72 hours after application*** *(NYSDOH, 2011)*

1st Date given:_____ Date read by Health Care Provider:_____ Results: ☐ NEG ☐ POS

2nd Date given:_____ Date read by Health Care Provider:_____ Results: ☐ NEG ☐ POS

****2nd PPD is required for all students who have not had an initial 2 step PPD and those who have not had annual PPDs***

**If PPD results are positive: Mandatory Chest X-Ray

CXR Date:_____ Results: ☐ NEG ☐ POS

☐ Student is unable to get PPD due to previous reaction or vaccination or chose to have an annual **QuantiFERON-TB gold test** performed (attach results)

3. **MEASLES/MUMPS/RUBELLA** ☐ 2 Vaccines after age 1 (list dates) **OR** ☐ Positive titers (attach lab report)

Titers:
Demonstrated proof of immunity to **Rubella** by positive antibody titer and /or re-immunization following a negative Rubella titer **or** proof of receiving 1 MMR immunization.

Demonstrated proof of immunity to **Measles** by positive antibody titer and/or re-immunization following a negative Rubeola titer **or** proof of receiving 2 MMR immunizations.

Demonstrated proof of immunity to **Mumps** by positive antibody titer and/or re-immunization following a negative Mumps titer **or** proof of receiving 2 MMR immunizations.

Vaccine dates: _____ _____

4. **VARICELLA** (chicken-pox)
Demonstrated proof of immunity to **Varicella by positive anti-body titer and/or re-immunization following a negative titer **or** proof of receiving 2 Varicella immunizations.

****Varicella: immunization dates: 1st dose:** _____ **2nd dose:** _____ **OR** Titer Drawn (date): _____
Titer Results (attach lab report): ☐POS ☐ NEG

If the immunity status for varicella (chicken pox) is unknown, it is **required** that the individual have a screening lab titer. If titer results do not prove immunity, the student will be required to have the varicella vaccine.

*****Anyone who is not fully vaccinated, and never had chickenpox, should receive one or two doses of chickenpox vaccine (NYSDOH)*****

5. **HEPATITIS B VACCINE** (If adult student declines, please sign waiver)

1st Dose_____ **2nd Dose**_____ **3rd Dose**_____ ☐ Waiver signed

Or: Titer: ☐POS ☐ NEG

6. **Tdap or Td VACCINE** (within the last 10 years) _____ Date Received

7. **Covid-19**: Although not required currently for school the vaccine is required for Clinical in both long term care and acute care.
   - *Up-to-date is defined by the CDC as receiving the Covid vaccine(s) and a booster(s). Currently a booster is **optional**.
   - Dates received & circle vaccine brand received (Moderna/Pfizer/J&J): 1st Dose: _____ 2nd Dose: _____
   - If booster received: Brand: _____ and Date: _____

Comments:

Health Care Provider completing form must sign this form and ***stamp with office stamp*** or it will be returned to student

Physician/Provider's Name/Phone (printed required) _____

Address_____

Signature_____Date_____

Please complete all sections or the Physical Exam form will be **returned to the student*