

STUDENT HEALTH HISTORY AND PHYSICAL EXAM

Teacher Name:	Class:		
Student First Name:	Student Last Name:		
Date of Birth:			
Home Street Address:	City:	State:	Zip:
Home Phone:	Cell Phone:		

**To Be Completed by Parent/Guardian
Parent/Guardian Consent Statement:**

- I give permission that a copy of this report may be sent to a clinical facility when requested.
- I give permission for my child to be randomly drug tested for Nassau BOCES at any hospital/nursing home as deemed necessary.

Signature: _____
(Parent/Guardian)

**To Be Completed by Student
Student Statement:**

I _____ consent to random drug testing for Nassau BOCES at any
(print student name) hospital/nursing home as deemed necessary.

Signature: _____
(Student)



DEPARTMENT OF REGIONAL SCHOOLS AND INSTRUCTIONAL PROGRAMS

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STUDENT HEALTH HISTORY AND PHYSICAL EXAM

Student First Name:	Student Last Name:	Date of Birth
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To Be Completed by Physician:

Date of Exam: __/__/__

Medical History

Check if any of the following pertain to the student. All items checked **MUST** have current status and treatment explained.

<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Asthma	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Heart condition	<input type="checkbox"/> Mental illness	<input type="checkbox"/> Orthopedic problems
<input type="checkbox"/> Gynecological problems	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Tuberculosis

Explanations: _____

Allergies

Drug allergies: _____

Food allergies: _____

Medication

Is the student taking any medication at the present time? ☐ No ☐ Yes

If yes, please specify: _____

Physical Examination

Height:	Weight:	Blood Pressure:	Pulse:	Respirations:
Vision:	Corrective Lenses:	<input type="radio"/> Yes <input type="radio"/> No		
Skin:		Musculoskeletal:		
Thyroid:	Nose:	Throat:	Lymph nodes:	
Neurological, speech, tremors, reflexes:				
Physical abnormalities: (describe)				

Student First Name:	Student Last Name:	Date of Birth
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To Be Completed by Physician

Date of Exam: __/__/__

Mandatory	Date	Notes:
Influenza shot	/ /	
QuantiFERON-TB Gold (QFT)	_/_/_	QFT OR 2 PPDs are required within below time frame <i>For NUMC ONLY – if you attend clinic last year, you are only required to get 1 PDD this year but must attach last year's PDD results. .</i>
Or		
PPD	/ /	Must be done after 7/01/24
1 st PPD result <input type="radio"/> Negative <input type="radio"/> Positive		If positive, Chest X-ray report required.
2 nd PPD	/ /	Must be done after 8/15/24
2 nd PPD result <input type="radio"/> Negative <input type="radio"/> Positive		If positive, Chest X-ray report required.
Diphtheria/Tetanus	/ /	Must be within 10 years
Hepatitis B1	/ /	It is highly recommended that all students be vaccinated for Hepatitis B
Hepatitis B2	/ /	
Hepatitis B3	/ /	
COVID-19	/ /	

Mandatory Titres & Laboratory Results

Please document results from the following and attach lab reports. If the titres do not show immunity, please provide proof of a booster shot. **Please note:** For all students/instructors *attending clinic for the 1st time*, Titre Blood Tests are mandatory. For students/instructors returning to clinic for a 2nd year titre blood tests do not have to be repeated, **but results and lab reports must be resubmitted**. Please attach copy of immunization record.

	Date:	Results:	Booster Vaccine (if needed)
Hemoglobin & Hematocrit	_/_/_		
Routine Urinalysis	/ /		
Rubeola Titre	/ /		
Rubella Titre	/ /		
Mumps Titre	/ /		
Varicella Titre	/ /		

Examining Physician's Statement: The above named student can assume, without any limitations, classroom and clinical assignments. He/she is free at this time for any habituation or addiction to alcohol or drugs that may be a potential risk to Hospital Patients or Nursing Home residents.

Physician Signature and Stamp	
Physician Name (print) :	Date:
Street Address:	
Telephone:	

Attach Lab Results: ☐ Rubeola Titre ☐ Rubella Titre ☐ Mumps Titre ☐ Varicella Titre ☐ Documentation of booster immunization (only for low immunity titers) ☐ Chest X-Ray (only if positive PPD result)