LIU Brooklyn

SCHOOL OF: Nursing☐ Health Professions☐ Education☐ CSD☐

Clinical Affiliation & Physical Examination

PRE/NUR☐ NUR/CLIN☐ MHC☐
AT/SS☐ DMS☐ HS☐ MPH☐ OT☐ PA☐ PT☐ RC/RT☐

STUDENT NAME (Last, First) STUDENT ID# DATE OF BIRTH SEX E-MAIL MAJOR

HOME ADDRESS (Number & Street) CITY or TOWN STATE/COUNTRY ZIP

HOME NO. CELL NO. EMERGENCY CONTACT PHONE NO.

To be completed by STUDENT: PERSONAL HISTORY [*Student: Please complete this page before going to your physician for examination*]

HAVE YOU HAD:	Yes	No		Yes	No
Scarlet Fever			Insomnia		
Measles			Frequent Anxiety		
German Measles			Frequent Depression		
Mumps			Worry or Nervousness		
Chicken Pox			Recurrent Headaches		
Malaria			Recent Colds		
☐ Gum ☐ Tooth Trouble			Head injury with Unconsciousness		
Sinusitis			☐ Hay Fever ☐ Asthma		
Eye Trouble			Tuberculosis		
☐ Ear ☐ Nose			Shortness of Breath		
☐ Throat Trouble					
			Allergy		
Surgery			Penicillin		
Appendectomy			Sulfonamides		
Tonsillectomy			Serum		
Hernia Repair			Foods (which)		
Other			Other		
Chest			Gallbladder Trouble		
☐ Pain ☐ Pressure			or Gallstones		
Chronic Cough			Recurrent Diarrhea		
Palpitations (Heart)			☐ Rupture ☐ Hernia		
High Blood Pressure			Recent Weight		
Low Blood Pressure			☐ Gain ☐ Loss		
Rheumatic Fever			☐ Dizziness ☐ Fainting		
Heart Murmur			☐ Weakness ☐ Paralysis		
Joint Problems:			☐ Epilepsy ☐ Convulsions		
Trick Knee					
Shoulder			Smoker – How many per day		
Back Problems					
☐ Tumor ☐ Cancer ☐ Cyst			**FEMALES ONLY**		
Jaundice			Irregular Periods		
Stomach Trouble			Severe Cramps		
Intestinal Trouble			Excessive Flow		
☐ Diabetes ☐ Hypoglycemia					

STUDENT AFFIDAVIT: I hereby certify that all information entered is complete and accurate.

Student Signature _____ **Date** _____

Student Name: _____

To be completed by a PHYSICIAN:

[Providers: Please fill-in all information, only attach requested items]

IMMUNIZATIONS and TESTS– Please give complete dates (Month/Day/Year)

	Results must be documented on this form as **Positive.** *If not providers must follow CDC/DOH requirements before approving for clinical*	*Date* *(Use to document required booster shots and actual vaccinations for HEP B, TETANUS AND FLU)*	*Quantitative Labs Results* ***Required***
Rubeola (Measles)			
Mumps			
Rubella			
Varicella			
HBV Shot Series **(PA required)**	N/A		N/A
HEP B Surface AB Titres (Results must be documented on this form as **Reactive)**			
HEP B Waiver	N/A	N/A	
Tetanus Toxoid **(NUR/PA required)**			
Flu Vaccine **(NUR/PA required)**	N/A		N/A

I HAVE EXAMINED THE FOLLOWING: (Must be completed by Physician)

	FINDINGS:
1. Head, Ears, Nose, & Throat	
2. Respiratory	
3. Cardiovascular	
4. Gastrointestinal	
5. Hernia(s)	
6. Eyes	
7. Genitourinary	
8. Musculoskeletal	
9. Metabolic/Endocrine	
10. Neuropsychiatric	
11. Skin	

Tuberculin Skin Test (TST) (Mantoux) **Mandatory (PPD)**

Date Administered: _____

Date Read: _____ Results: _____mm

TST Read by: _____

If TST/Mantoux is positive, chest X-ray is required and **current report within past three years must be attached**

CXR Date:_____ Results_____

Has medication been prescribed? _____

Medication: _____

Duration: _____

This sections must be completed:

Height _____ Weight _____

Blood Pressure _____

Vision: R _____ L _____ Corrected: R _____ L _____

Hemoglobin (if indicated): _____gms%

Please check one of the following:

_____ May participate in clinical experience in health care agencies or organizations.

_____ Must be restricted or adaptive program designed for her/his physical limitations. Indicate specific limits.

_____

_____ Should not participate in clinical experiences.

Physician's Signature _____ Physician's License # _____

Print Name _____

Address _____

_____

Date_____

STAMP REQUIRED: