

HARTWICK COLLEGE DEPARTMENT OF NURSING

NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_

ANNUAL PHYSICAL EXAM RECORD

Annual Tuberculin Testing

Mantoux/PPD Date \_\_\_\_\_ Results \_\_\_\_\_ mm induration \_\_\_\_ Pos. \_\_\_\_ Neg.

If test is positive a chest x-ray is required.

Date of x-ray \_\_\_\_\_ Results \_\_\_\_\_

If PPD positive, was treatment taken? \_\_\_\_ Yes \_\_\_\_ No

Medication \_\_\_\_\_ Date started \_\_\_\_\_ Date completed \_\_\_\_\_

Influenza Vaccine(s) Date (s) \_\_\_\_\_

EXAM

Vision Corrected Uncorrected Color Vision \_\_\_\_\_
OD 20/\_\_\_\_ 20/\_\_\_\_ Hearing \_\_\_\_\_
OS 20/\_\_\_\_ 20/\_\_\_\_ Test Used \_\_\_\_\_

#+= normal X=abnormal Temp \_\_\_\_\_
\_\_\_\_head \_\_\_\_lungs \_\_\_\_genital
\_\_\_\_eyes \_\_\_\_extremities \_\_\_\_rectal Pulse \_\_\_\_\_
\_\_\_\_ears \_\_\_\_skin \_\_\_\_prostate Resp \_\_\_\_\_
\_\_\_\_nose \_\_\_\_heart \_\_\_\_pelvic BP \_\_\_\_\_
\_\_\_\_throat \_\_\_\_breast \_\_\_\_back Height \_\_\_\_\_
\_\_\_\_neck \_\_\_\_abdomen \_\_\_\_circulation Weight \_\_\_\_\_
\_\_\_\_thyroid \_\_\_\_hernia \_\_\_\_neuro

Comments \_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

After reviewing this individual's history and completing a physical examination, I have found him/her to be in satisfactory physical condition to care for clients. Yes \_\_\_\_ No \_\_\_\_\_

Limitations which prohibit the individual from providing nursing care to clients should be documented by the physician.

\_\_\_\_\_
\_\_\_\_\_

Healthcare Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Telephone \_\_\_\_\_

RELEASE OF INFORMATION

I certify that the above information is true and correct to the best of my knowledge.

I grant permission for this information to be released to the clinical facilities where I shall be a student.

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