HARTWICK COLLEGE
est. 1797

Nursing Annual Physical Exam Record

Returning Nursing Majors Only. Must be completed by health care provider.
Keep a copy for your records. Questions? Call Perrella Health Center at 607-431-4120.

Mail to: Perrella Health Center, Hartwick College, P.O. Box 4020, Oneonta, NY 13820
Fax: 607-431-4124 | **e-mail:** healthcenter@hartwick.edu

_____ ____/____/____ ____/____/____
Student name Date of Birth Date of Exam

RELEASE OF INFORMATION: Must be signed by student

I hereby state that the information provided on this form is correct to the best of my knowledge. , I authorize documentation regarding my annual physical, tuberculosis screening, and immunization status to be released to the nursing department and any clinical facilities where I will be a student.

_____ ____/____/____
Student Signature **Date**

_____ ____/____/____
Parent/Guardian Signature (if student is under 18 years of age) **Date**

ANNUAL TUBERCULOSIS TESTING

Mantoux/TST
Date planted: ____/____/____ Date read: ____/____/____
Results: _____ mm induration ☐ Pos. ☐ Neg.

OR

Quantiferon Gold
Result: ☐ Pos. ☐ Neg.
Copy of result must be attached.

If test is positive or a history of a positive tuberculosis screen, a *one time* chest x-ray is required.

Date of x-ray: ____/____/____ Results: _____ (attach copy) If positive test, was treatment initiated? ☐ Yes ☐ No

Medication(s): _____ Date started: ____/____/____ Date completed: ____/____/____
Per CDC guideline annual chest x-ray is NOT recommended.

Most Recent Influenza Vaccine Date: ____/____/____

SARS-CoV-2 Vaccine Date(s): ____/____/____ ____/____/____ Brand _____

EXAMINATION **normal - X** **abnormal - explain**

Vision _____

	Corrected	Uncorrected
OD:	20/____	20/____
OS:	20/____	20/____

Color Vision _____
Hearing _____
Test Used _____

Head _____ Skin _____ Circulation _____
Eyes _____ Heart _____ Neuro _____
Ears _____ Breast _____
Nose _____ Abdomen _____ Temp: _____
Throat _____ Hernia _____ BP: _____
Neck _____ Genital _____ Pulse: _____
Thyroid _____ Rectal _____ Resp: _____
Chest _____ Prostate _____ Height: _____
Lungs _____ Pelvic _____ Weight: _____
Extremities _____ Back _____

STATEMENT OF FITNESS: Must be filled out and signed by health care provider

After reviewing this individual's history and completing a physical examination, I have found her/him to be in satisfactory physical condition to wear respiratory protection and care for clients unless otherwise noted below.

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

_____

Fit tested for respirator use ☐ Yes ☐ No Type of respirator _____

_____ _____ ____/____/____
Healthcare Provider Signature **Phone#** **Date**