Date of first term:

Fall Spring Summer

Year_____

UNIVERSITY OF SAINT JOSEPH
CONNECTICUT

Health Services
Phone: 860.231.5530
Fax: 860.231.6794

PHYSICAL EXAM AND VACCINE FORM: PHARMACY/NURSING/DIETETIC INTERN/PHYSICIAN ASSISTANT

Name_____ Birth date____/____/_____ Birth place_____

Home Address _____
Street *Apt or Unit #* *City* *State* *Zip*

Home phone _____ Student cell phone_____ Student e-mail_____

STUDENT AND HEALTH CARE PROVIDER-Medical History

Please check (√) all that apply and provide an explanation in the space below. Attach an additional page as needed.

_____ seizures _____ diabetes _____ heart problems _____ mononucleosis _____ thyroid condition _____ concussion

_____ surgery _____ asthma _____ **allergies** _____ food intolerance _____ mental health _____ sickle cell

_____ high blood pressure _____ latex allergy _____ ovarian cyst _____ none _____ other (explain)

_____

_____

HEALTH CARE PROVIDER-Physical Examination <Exam within last 12 months> Exam date_____

Height _____ Weight _____ LMP (females)_____ *** Nursing Students Only ***
Ishihara Color Blind Screen

B/P _____ Pulse_____ Vision Screen _____ Pass Fail Not Done

System	Findings	System	Findings
HEENT		Abdomen	
Neck/Thyroid/Lymphatics		Musculoskeletal	
Cardiac		Neurological	
Lungs		Skin	

MEDICAL RECOMMENDATIONS & TREATMENTS (Attach sheet if more space needed/additional documentation required for latex allergy)

____ Based on my examination, this individual is free of signs or symptoms of communicable disease, including Tuberculosis

____ Can perform all activities including clinical rotations and academic courses without restriction

____ Can perform above activities with these limitations:_____

Medication	Dose	Frequency

MD/APRN/PAC name_____ Signature_____ Date_____

Phone number _____ Fax number_____ 2/17 version

Name _____ DOB _____/_____/_____ Gender_____

HEALTH CARE PROVIDER-VACCCINES AND TUBERCULOSIS TESTING

Required-Section 1

2 doses of both MMR and Varicella (chickenpox) vaccines required. Titer required in instance of natural Varicella disease. Lab reports must be attached. Perform titers when incomplete or no records are available. Titers are not required when vaccine history is complete. Date of birth exemptions not allowed for health professions students.

	MMR
Dose 1	
Dose 2	

	Varicella
Dose 1	
Dose 2	

Titer	Result
Measles/Rubeola	
Rubella	
Mumps	
Varicella	

Boosters required for: MMR or Varicella vaccines given before age 1, less than 28 days apart or for a non-immune result. For an equivocal result administer one booster. For a low or negative result, two boosters appropriately sequenced are required.

Influenza vaccine required for all health professions students for rotations-new Physician Assistant students must attach current season influenza vaccine record. Lot number and expiration date must be shown with administration record.

Required-Section 2: Hepatitis B antibody titer required (in addition to vaccine series) by some rotations sites, but not by USJ **except** when vaccine series records not available or are incomplete. Post-vaccination titers (quantitative) recommended for students currently completing series or when vaccines were not administered by the standard schedule.

	Hepatitis B		DTP/Tdap
Dose 1		Date series completed	
Dose 2		Total # doses	
Dose 3		Tdap booster only ____ (√) to verify Tdap given	

*** Office Stamp***

IMPORTANT: Hospitals require a "Tdap" vaccine for rotations. Do not substitute at Td for Tdap-please leave blank and direct student to other resources if a Tdap is not available in your practice. Please acknowledge Tdap was given as noted.

TUBERCULOSIS TESTING

Pharmacy, Physician Assistant, Dietetic Intern and all clinical nursing students must have "2 Step" testing unless contraindicated. A distinct second PPD should be administered 1 to 3 weeks after first PPD.

Test performed: PPD#1 IGRA Date given: _____/_____/_____ Date read: ____/_____/____ Results:_____

"2 Step" (as applies) PPD # 2 Date given: _____/_____/_____ Date read: ____/_____/____ Results:_____

*IGRA testing encouraged for BCG vaccinated persons. Where applicable please **attach** IGRA test results and/or chest x-ray reports and treatment dates. Students with a positive PPD test are required to submit a chest x-ray report, any applicable treatment records and the USJ risk/symptom questionnaire found in your health forms packet. Graduate nursing students must also have a provider statement clearing for rotations (on letterhead).*

STUDENT-Emergency contact

Name _____ Relationship _____

Phone # 1 _____ Phone # 2_____ Include extension # where applicable

In the event of an emergency, I authorize the University of Saint Joseph to provide or arrange for medical care if either I or my emergency contact are unable give timely consent. I understand I need to notify Health Services for any significant health changes.

Student signature _____ Date _____

Return form to Health Services by fax 860.231.6794 or mail: University of Saint Joseph, 1678 Asylum Avenue, West Hartford, CT 06117