WASHINGTON•SARATOGA
BOCES
BOARD OF COOPERATIVE EDUCATIONAL SERVICES
WARREN•HAMILTON•ESSEX

Return to:
WSWHE BOCES
SAEC- Attn: Practical Nursing
1051 Dix Ave, Bldg C
Hudson Falls, NY 12839
Fax: 518-746-3409

# PHYSICAL EXAMINATION HEALTH FORM
## (To be completed by physician)

**IDENTIFICATION DATA:**

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ TELEPHONE #_____

_____

IN CASE OF EMERGENCY CALL: _____

RELATIONSHIP: _____ TELEPHONE #_____

ADDRESS: _____

_____

_____

**PHYSICAL EXAM FORM:**

HEIGHT: _____ WEIGHT: _____ T._____ P._____ R._____ B.P._____

VISION:

(Without corrective lenses) Right: _____ Left: _____

(With corrective lenses: Right: _____ Left: _____

HEARING: Right ear: _____ Left ear: _____ Hearing aid: _____ Yes _____ No

ANY SURGERY OR SERIOUS ILLNESS: _____

_____

| | NORMAL | ABNORMAL | COMMENTS: |
|---|---|---|---|
| | | | |
| **EYES** | | | |
| **EARS** | | | |
| **NOSE** | | | |
| **MOUTH & THROAT** | | | |
| **NECK** | | | |
| **HEART** | | | |
| **LUNGS** | | | |
| **BREASTS** | | | |
| **ABDOMEN** | | | |
| **BACK REFLEXES** | | | |



(Continued on page 2)

_____

**IMMUNIZATION STATUS:**

A. 1) *PPD Skin Test ( ) Aplison ( ) Tubersol **2 step required** **for *health* programs providing direct care**
**#1** Date Given: _____ Date Read: _____ **#2** Date Given_____ READ_____
Results: _____ Results: _____

2) For conversion (must have proof of following with in last 5 years).
Date of Conversion: _____ Clinical follow up: Yes ___ No ___ Where _____
Date of Chest X-Ray _____ Results _____

B. *Rubella Date of Vaccine _____ **OR** Date of Titer: _____ Results _____

*Rubeola Date of Vaccine _____ **OR** Date of Titer: _____ Results _____

Mumps Date of Vaccine _____ **OR** Date of Titer: _____ Results _____

C. MMR: Dose 1 - Date:_____
MMR: Dose 2 - Date: _____

D. Tetanus Date: _____ ( **current within 10 years**)

E. Hepatitis B Vaccine :#1_____ #2_____ #3_____

Positive Titer date _____ attach documentation

F. Varicella: Dose 1- Date_____ Dose 2- Date_____ Positive HX disease/**Titer**__ _____- attach documentation

G. Seasonal Flu: ( last dose)_____

This is to certify that _____ is in good physical and mental health and is **free from any impairment which poses a potential risk to patients or personnel. He/She is physically able to perform his/her duties as a practitioner in clinical affiliations**.

_____ _____
Physician's Signature Date

Print Name _____

Results of the History and Physical examination and immunization status will be retained at the school and will be available to New York State Department of Health, New York State Education Department, or Hospital Health Office should the need occur.

*PPD (Mantoux) skin test for the tuberculosis is required annually by New York State Department of Health as a condition of employment or affiliation. Positive findings shall require appropriate clinical follow-up, but no repeat skin test .A NEW HEALTH CARE PROVIDER MUST HAVE A TWO STEP PPD WITH ANNUAL UPDATES.

*Rubella proof of immunity by titer or documented vaccination is required by new York State Department of Health as a condition of employment or affiliation.

*ALL STUDENTS - Rubeola proof of immunity by titer or documented evidence of 2 doses of measles vaccine is required by New York State Department of Health as a condition of employment or affiliation.

2/2012