ETA
EMPLOYMENT TRAINING FOR ADULTS
What's Your ETA?
A Division of WSWHE BOCES

WSWHE BOCES
Southern Adirondack Center
Myers Education Center
Voice: 518-581-3555 or Fax: 518-581-3698

PHYSICAL EXAMINATION HEALTH FORM

(To be completed by physician)

IDENTIFICATION DATA:

Name: _____ Date of Birth: _____

Address: _____ Telephone # _____

_____

In Case of Emergency – please 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 ____ or No____

	NORMAL	ABNORMAL	COMMENTS
Eyes			
Ears			
Nose			
Mouth & Throat			
Neck			
Heart			
Lungs			
Breasts			
Abdomen			
Back Reflexes			

List any surgeries or serious illnesses: _____

_____

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IMMUNIZATION STATUS

TYPE	DATE OF VACCINE
MMR	Dose 1: _____ Dose 2: _____
Tenanus	_____ (must be current – within 10 years)
Hepatitis B Vaccine	Dose 1: _____ Dose 2: _____ Dose 3: _____
Positive Titer	_____ (attach documentation)
Varicella	Dose 1: _____ Dose 2: _____ Positive HX disease/Titer_____ (attach documentation)
Seasonal Flu	_____ (last dose)

TYPE	DATE OF VACCINE	OR	DATE OF TITER	RESULTS
*Rubella				
*Rubeola				
Mumps				

This is to certify that _____ is in good physical and mental health and is free from any impairment which posers a po0tential 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 examinations 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 does of measles vaccine is required by New York State Department of Health as a condition of employment or affiliation.

Revised 8/24/2017

Glens Falls Hospital

Name: _____

Date of Birth: _____

GLENS FALLS HOSPITAL

Job Shadow/Intern Medical Clearance Requirements

The purpose of this form is to notify job shadow/interns and all instructors/job coaches of Glens Falls Hospital's medical clearance requirements. In order to participate in these programs the following medical documentation must be submitted:

TUBERCULOSIS:

Has the student ever had a TB Skin Test _____ Yes _____ No

If Yes, Result _____ Negative _____ Positive

Received preventive therapy _____ Yes _____ No

Chest x-ray Date: _____ Report: _____ Negative _____ Positive

Documentation: _____ Yes _____ No Nurse: _____

	Test #1	Test #2
Date Given		
Solution/TFG Lot # & Expiration Date		
Site	L R ForeArm	L R ForeArm
Given By		
Date Read		
Results in MM	Mm	mm
READ BY: (Please note: TB tests results must be interpreted by RN, NP, PA or MD)	___ Positive ___Negative _____ _____ Name Title	___ Positive ___Negative _____ _____ Name Title

Revised 8/24/2017