

HEALTH CARE PROVIDER'S REPORT OF HEALTH EVALUATION

PART II – PHYSICAL EXAMINATION

Student's Name _____

Date of Birth _____

1. Height _____ 2. Weight _____ 3. Blood Pressure _____ / _____ 4. Pulse _____

5. Vision Right 20/ _____ corrected to 20/ _____

Left 20/ _____ corrected to 20/ _____

DESCRIBE ANY ABNORMALITIES OF THE FOLLOWING SYSTEMS IN THE SPACE BELOW.

	NORMAL	ABNORMAL
6. Head, Ears, Nose, or Throat		
7. Eyes (Ophthalmoscopic)		
8. Hearing		
9. Neck – Thyroid		
10. Respiratory		
11. Cardiovascular		
12. Gastrointestinal		

	NORMAL	ABNORMAL
13. Skin		
14. Genitourinary (including Hernia)		
15. Musculoskeletal		
16. Metabolic/Endocrine		
17. Neurological		
18. Psychiatric		

	Yes	No
19. To the best of your knowledge, is this person free from physical or mental impairments including alcohol or drug dependency?		
20. To the best of your knowledge, is this person free from communicable diseases that could jeopardize the health of patients or classmates?		
21. Are there any restrictions of physical activity indicated by your examination? Comment below.		
22. Is the patient now under treatment for any medical or emotional condition? Comment below.		
23. Do you have any recommendations regarding the care of this student? Comment below.		
24. Is the person capable of performing the work assigned to him/her in the practice setting as a physician assistant/physical therapy student or nurse?		
25. How long and in what capacity have you known this student?		

Comments:

PART III – IMMUNIZATIONS

IMMUNIZATIONS: MANDATORY

MMR 1 _____ MMR 2 _____ OR DATES:

26. Measles: 2 doses vaccine _____

or proof of disease _____

or pos. serologic test (attach lab report) _____

27. Mumps: mumps vaccine _____

or proof of disease _____

or pos. serologic test (attach lab report) _____

28. Rubella: rubella vaccine _____

or pos. serologic test (attach lab report) _____

29. Varicella: 2 vaccines _____ 2 _____

or proof of disease _____

or pos. serologic test (attach lab report) _____

30. PPD **within 1 year mandatory.**
Results to be read within 72 hours
(IF TEST IS POSITIVE, CHEST X-RAY IS REQUIRED). See #31.

(Date Administered)

(Date Read)

POS ____ mm. NEG ____ mm.

31. Chest X-ray Date _____
(NEEDED ONLY IF PPD RESULT IS POSITIVE)
(Please attach a copy of the report) Result _____

32. TD Date _____
or TDAP Date _____

33. Hepatitis B
1st Dose Date _____
2nd Dose Date _____
3rd Dose Date _____

34. Positive Hep B titer Date _____

35. Flu Vaccine Date _____

I verify by my signature that the student I have examined is able to meet the Technical Standards for successful completion of the Daemen College Athletic Training Education/Nursing/PA or PT Program. My signature also verifies that I have reviewed the student's immunization records.

Signed _____, Title _____

Name _____
(PRINT)

Address _____
_____ Zip _____

Tel. No. (Include area code) () _____

Date of Examination _____

WHEN COMPLETED, MAIL DIRECTLY TO:

Health Services Office – M.B. #104
Daemen College
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Amherst, New York 14226-3592

(716) 839-8446
FAX (716) 839-8230