PLEASE RETURN ORIGINAL TO D'YOUVILLE COLLEGE HEALTH CENTER
CLINICAL PLACEMENT MEDICAL CERTIFICATION/ASSESSMENT

This clinical physical is for: ❑ Chiropractic ❑ Dietetic ❑ Nursing ❑ OT ❑ PA ❑ PT ❑ Pharmacy

SSN#: _____ **Date of Birth:** _____

NAME: _____
LAST FIRST MIDDLE

LOCAL ADDRESS: _____
STREET CITY

_____
STATE ZIP AREA CODE PHONE NUMBER

HEALTH INSURANCE COVERAGE

NAME OF COMPANY: _____

POLICY #: _____ **GROUP#:** _____

TO BE COMPLETED BY STUDENT

Please check those conditions for which you have a history:

- ❑ Anemia/Blood disorder
- ❑ Arthritis/Joint Problems
- ❑ Asthma/Hayfever
- ❑ Heart Disease/Murmur
- ❑ Tuberculosis
- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Allergies to Foods or Drugs
- ❑ Infectious Mononucleosis
- ❑ Kidney/Urinary Problems
- ❑ Fainting/Convulsions/Epilepsy
- ❑ Skin Rashes/Sores
- ❑ Draining Wounds/Infections
- ❑ Hernia
- ❑ Ulcer/Gastroenteritis
- ❑ Emotional Problems
- ❑ Back Pain
- ❑ Blood Producing Cough
- ❑ Hepatitis
- ❑ Diarrhea
- ❑ Jaundice
- ❑ Change in Bowel Habits
- ❑ Blood in your stools
- ❑ Cough

NOTE:

- ✔ Keep one (1) copy of all forms for your records.
- ✔ Submit a copy of PAGE 3 and 4 to your program office.
- ✔ Return entire ORIGINAL to: Health Center, D'Youville College, 505 Prospect Ave., Buffalo, NY 14201
- ✔ Student is responsible for making all copies.

Name: _____ **Date of Birth:** _____

1. Are you currently under the care of a physician? ❑ **Yes** ❑ **No**

If "Yes", please explain _____

2. Are you currently on any medication? ❑ **Yes** ❑ **No**

If "Yes", please explain _____

3. Do you have any problems with your vision? ❑ **Yes** ❑ **No**

If "Yes", please explain _____

4. Do you have any allergies to food, drugs, pollens, latex, etc.? ❑ **Yes** ❑ **No**

If "Yes", please specify: _____

5. How many colds have you had in the past year? _____ How long do they normally last? _____

6. Do you smoke? _____ What? _____ How many per day ? _____

7. In the past year has there been any change in your:

a. Weight? _____ How much? _____

b. Blood Pressure? _____ How much? _____

D'Youville COLLEGE

Educating for life

CLINICAL PLACEMENT MEDICAL CERTIFICATION/ASSESSMENT
TO BE COMPLETED BY PHYSICIAN, NP, or PA

NAME: _____ DOB: _____

HEIGHT: _____ WEIGHT: _____ BP: _____ PULSE: _____

VISION WITHOUT GLASSES: R: _____ L: _____ VISION WITH GLASSES: R: _____ L: _____

CHECK EACH ITEM IN PROPER COLUMN. ENTER "NE" IF NOT EVALUATED.

	Normal	Abnormal	Comments
1. Head, Neck, Face, Scalp, Skin	❑	❑	
2. Ears, Nose & Throat	❑	❑	
3. Oral Cavity	❑	❑	
4. Lungs, Chest	❑	❑	
5. Heart	❑	❑	
6. Abdomen & Viscera	❑	❑	
7. Musculoskeletal	❑	❑	
8. Hearing	❑	❑	

Limitations, if any: _____

ALLIED HEALTH DEPARTMENTS' LIST OF REQUIRED IMMUNIZATIONS

1. **PPD (Mantoux within 1 year):** Date: _____ Result: Positive☐ Negative☐

   Nursing and Pharmacy Students: 2nd PPD Date: _____ Result: Positive☐ Negative☐

   (If PPD is positive, CXR must be obtained and copy of the report must be on file in Health Center)

   Chest X-ray: Date: _____ Result: _____

Please Note: For Mumps/Measles/Rubella Vaccines, must have documentation of either having received individual vaccines OR MMR vaccination previously. If prior vaccination documentation is not available, then documentation of immune serology for each component of the MMR vaccine is required as follows:

2. **Rubeola (Measles) Live Vaccine:** 1st dose Date: _____ 2nd dose Date: _____

   (Two doses measles vaccination required, with first dose given on or after first birthday, and second dose separated by at least 28 days OR immune serology with lab report on file in Health Center)

   Rubeola (Measles) Titer: Date: _____ Result: _____

3. **Mumps Vaccine** 1st dose Date: _____ 2nd dose Date: _____

   (Two doses of mumps vaccination required, with first dose given on or after first birthday, and second dose separated by at least 28 days OR immune serology with lab report on file in Health Center)

   Mumps Titer: Date: _____ Result: _____

4. **Rubella Live Vaccine:** Date: _____

   (One dose live rubella vaccination required, with first dose given on or after first birthday OR immune serology with lab report on file in Health Center)

   Rubella Titer: Date: _____ Result: _____

5. **Tetanus/diphtheria [Td]**
(booster within 10 years) Date: _____

(If most recent Td booster received at least two years ago, please see Tetanus/diphtheria/acellular pertussis [Tdap] information below) OR

Tetanus/diphtheria/acellular pertussis [Tdap] Date: _____

(In keeping with current Centers for Disease Control recommendations, health care personnel younger than age 65 with direct patient contact who have not previously received a dose of Tdap, should receive a single dose of Tdap to replace one Td booster dose. **Waiting at least 2 years since last Td booster is suggested)**

6. **Hepatitis B Series:** 1st dose Date: _____ 2nd dose Date: _____ 3rd dose Date: _____

Hepatitis B Titer: Date: _____ Result: _____

7. **Varicella Zoster Vaccine** 1st dose Date: _____ 2nd dose Date: _____
(required for nursing and PA students)

Varicella Titer Date: _____ Result: _____

(Immune serology with lab report on file in Health Center) OR

(All persons age 13 years and older without evidence of immunity to varicella are required to have two doses of varicella vaccine, separated by at least 4 weeks)

8. **Influenza Vaccine (annual)** Date: _____

(In keeping with current Centers for Disease Control recommendations, it is recommended that all health care personnel without known contraindications should receive an annual influenza vaccine)

Healthcare Provider Signature **Date**

Print or Stamp here

Address **(Area Code) Telephone**

I am aware and understand that:
In order to maintain the health and safety of their clients and meet designated health laws, agencies used for clinical and/or field placement experience, may require selected information from my health record. I authorize release of page three and four to said agencies and to the program office. I also concur that the information above, attested to by my physician, is true.

Signature of Student Date