D'Youville

PHYSICAL ASSESSMENT FOR CLINICAL PLACEMENT

COMPLETED BY STUDENT (PAGES 1 & 2)

HEALTH CENTER
Marguerite Hall • 1st Floor
505 Prospect Avenue • Buffalo, N.Y. 14201
Phone: 716.829.8777
Fax: 716.829.7646
healthcenter@dyc.edu

THIS CLINICAL PHYSICAL IS FOR: ☐ **DIETETICS** ☐ **NURSING** ☐ **OT** ☐ **PA** ☐ **PT** ☐ **CHIROPRACTIC**

DATE OF BIRTH: _____/_____/_____
M D Y

NAME: _____
Last Name *First Name* *M.I.*

ADDRESS (LOCAL): _____
Street *City* *State/Province* *Zip/Postal Code*

TELEPHONE NUMBER WITH AREA CODE: (_____)_____

HEALTH INSURANCE COVERAGE:

_____
Company Name *Policy Number* *Group*

COMPLETED BY STUDENT

PLEASE CHECK (X) THOSE CONDITIONS FOR WHICH YOU HAVE A HISTORY:

- ☐ Anemia / Blood Disorder
- ☐ Arthritis / Joint Problems
- ☐ Asthma / Hay Fever
- ☐ 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 copy of all forms for your records.**
- **Submit a copy of pages 4 to your program office.**
- **Return entire ORIGINAL to: Health Center, D'Youville College, 505 Prospect Avenue, Buffalo, N.Y. 14201**
- **Student is responsible for making all copies.**

NAME: _____ **DATE OF BIRTH:** _____/_____/_____
M D Y

1. **ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?**

☐ YES ☐ NO

If "Yes," please explain: _____

2. ARE YOU CURRENTLY ON ANY MEDICATION(S)?

☐ 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, ETC.?

☐ YES ☐ NO

If "Yes," please explain: _____

5. HOW MANY COLDS HAVE YOU HAD IN THE PAST YEAR? _____ **HOW LONG DO THEY NORMALLY LAST?** _____

6. DO YOU SMOKE?

☐ YES ☐ NO

What? _____ *How many per day ?* _____

7. IN THE PAST YEAR HAS THERE BEEN ANY CHANGE IN YOUR:

a. Weight? ☐ YES ☐ NO How much?_____

b. Blood Pressure? ☐ YES ☐ NO How much?_____

NAME: _____ DATE OF BIRTH: _____/_____/_____
M D Y

PHYSICAL ASSESSMENT/ CERTIFICATION FOR CLINICAL PLACEMENT

MUST BE COMPLETED BY AN MD, DO, NP, PA

(PAGES 3 & 4)

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NAME: _____ DATE OF BIRTH: _____/_____/_____
M D Y

Height: _____ Weight: _____

BP: _____ Pulse: _____

Date of Exam: _____/_____/_____

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

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

Head, Neck, Face, Scalp, Skin	☐	NORMAL	☐	ABNORMAL	COMMENT	_____
Ears, Nose & Throat	☐	NORMAL	☐	ABNORMAL	COMMENT	_____
Oral Cavity	☐	NORMAL	☐	ABNORMAL	COMMENT	_____
Lungs, Chest	☐	NORMAL	☐	ABNORMAL	COMMENT	_____
Heart	☐	NORMAL	☐	ABNORMAL	COMMENT	_____
Abdomen & Viscera	☐	NORMAL	☐	ABNORMAL	COMMENT	_____
Musculoskeletal	☐	NORMAL	☐	ABNORMAL	COMMENT	_____
Hearing	☐	NORMAL	☐	ABNORMAL	COMMENT	_____

LIMITATIONS, IF ANY: _____

REQUIRED SIGNATURE

_____ Date: _____/_____/_____
PHYSICIAN'S SIGNATURE

PRINT OR STAMP HERE _____

ADDRESS: _____ PHONE: _____

NAME: _____ **DATE OF BIRTH:** _____/_____/_____
M D Y

ALLIED HEALTH DEPARTMENTS LIST OF REQUIRED IMMUNIZATIONS

PLEASE CONTACT YOUR HEALTH PROFESSION PROGRAM FOR SPECIFIC IMMUNIZATION REQUIREMENTS.
COPIES OF ALL TITERS MUST BE SENT TO HEALTH OFFICE.

1. PPD *(Mantoux within 1 year)*: Date placed:_____/_____/_____ Date Read:__/_____/_____ Reaction (mm) _____

2ND PPD: Date placed: _____/_____/_____ Date Read:__/_____/_____ Reaction (mm) _____

** (If PPD is positive, a chest X-ray must be obtained and copy of the report must be on file in health center.)*

CHEST X-RAY: _____/_____/_____ **RESULT:** _____

2. MMRs Two dates of MMR immunization: 1: _____/_____/_____ 2: _____/_____/_____

OR ITEMS 3-5

3. MEASLES (RUBEOLA) IMMUNITY *(Must have one of the following)*

Two dates of measles immunization: 1: _____/_____/_____ 2: _____/_____/_____

OR Date of positive measles titer: ____/_____/_____ **RESULTS:** _____ **Copy of titer required.**

4. MUMPS IMMUNITY *(Must have one of the following)*

Date of one mumps Immunization: _____/ _____/_____

OR Date of positive mumps titer: _____/ _____/_____ **RESULTS:** _____ **Copy of titer required.**

5. RUBELLA IMMUNITY *(Must have one of the following)*

Date of one rubella Immunization: _____/ _____/_____

OR Date of positive rubella titer: _____/ _____/_____ **RESULTS:** _____ **Copy of titer required.**

6. TETANUS / DIPHTHERIA [Td] *(booster within 10 years)* _____/_____/_____ or Tdap: _____/_____/_____
If most recent Td booster received was in 2006 or later, please see possible booster for Tetanus / diphtheria/acellular pertussis [Tdap] information below, or Tetanus / diphtheria / acellular pertussis [Tdap]

(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. **Waiting at least 2 years since last Td booster is suggested.**)

7. HEPATITIS B SERIES 1st dose: _____/_____/_____ 2nd dose: _____/_____/_____ 3rd dose: _____/_____/_____

HEPATITIS B TITER Date: _____/_____/_____ **RESULTS:** _____**Copy of titer required.**

8. VARICELLA ZOSTER VACCINE 1st dose: _____/_____/_____ 2nd dose: _____/_____/_____

VARICELLA TITER Date: _____/_____/_____ **RESULTS:** _____**Copy of titer required.**

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 four weeks

9. 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.

REQUIRED SIGNATURES

_____ **Date:** _____/_____/_____
PHYSICIAN'S SIGNATURE

PRINT OR STAMP HERE _____

ADDRESS: _____ **PHONE:** _____

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 this page to said agencies and to the program office. I also concur that the information above, attested to by my physician is true.

_____ **Date:** _____/_____/_____
STUDENT'S SIGNATURE