STUDENT HEALTH HISTORY AND PHYSICAL EXAM

Teacher Name:	Class:		
Student First Name:	Student Last Name:		
Date of Birth:			
Home Street Address:	City:	State:	Zip:
Home Phone:	Cell Phone:		

To Be Completed by Parent/Guardian
Parent/Guardian Consent Statement:

- I give permission that a copy of this report may be sent to a clinical facility when requested.
- I give permission for my child to be randomly drug tested for Nassau BOCES at any hospital/nursing home as deemed necessary.

Signature:_____
(Parent/Guardian)

To Be Completed by Student
Student Statement:

I _____ consent to random drug testing for Nassau BOCES at any hospital/nursing home as deemed necessary.
(print student name)

Signature:_____
(Student)

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DEPARTMENT OF REGIONAL SCHOOLS AND INSTRUCTIONAL PROGRAMS

STUDENT HEALTH HISTORY AND PHYSICAL EXAM

Student First Name:	Student Last Name:	Date of Birth

To Be Completed by Physician: **Date of Exam: __/__/__**

Medical History

Check if any of the following pertain to the student. All items checked MUST have current status and treatment explained.

_____ Seizure Disorder	_____ Thyroid disease	_____ Diabetes
_____ Asthma	_____ Scoliosis	_____ Hearing Loss
_____ Kidney Disease	_____ Hepatitis	_____ Rheumatic fever
_____ Heart condition	_____ Mental illness	_____ Orthopedic problems
_____ Gynecological problems	_____ Hypertension	_____ Tuberculosis

Explanations: _____

Allergies

Drug allergies: _____

Food allergies: _____

Medication

Is the student taking any medication at the present time? ○ No ○ Yes
If yes, please specify: _____

Physical Examination

Height:	Weight:	Blood Pressure:	Pulse:	Respirations:
Vision:	Corrective Lenses: ○ Yes ○ No			
Skin:		Musculoskeletal:		
Thyroid:	Nose:	Throat:	Lymph nodes:	
Neurological, speech, tremors, reflexes:				
Physical abnormalities: (describe)				

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DEPARTMENT OF REGIONAL SCHOOLS AND INSTRUCTIONAL PROGRAMS

Student First Name:	Student Last Name:	Date of Birth

To Be Completed by Physician **Date of Exam: __/__/__**

Mandatory	**Date**	**Notes:**
Influenza shot	__/__/__	
QuantiFERON-TB Gold (QFT)	__/__/__	QFT **OR** 2 PPDs are required within below time frame *For NUMC ONLY – if you attend clinic last year, you are only required to get 1 PDD this year but must attach last year's PDD results. .*
Or		
PPD	__/__/__	Must be done after 7/01/22
1st PPD result ○Negative ○ Positive		If positive, Chest X-ray report required.
2nd PPD	__/__/__	Must be done after 12/15/22
2nd PPD result ○Negative ○ Positive		If positive, Chest X-ray report required.
Diphtheria/Tetanus	__/__/__	Must be within 10 years
Hepatitis B1	__/__/__	It is highly recommended that all students be vaccinated for Hepatitis B
Hepatitis B2	__/__/__	
Hepatitis B3	__/__/__	
COVID-19 1st Dose	__/__/__	
COVID -19 2nd Dose	__/__/__	
COVID-19 Booster	__/__/__	

Mandatory Titres & Laboratory Results

Please document results from the following and attach lab reports. If the titres do not show immunity, please provide proof of a booster shot. **Please note:** For all students/instructors *attending clinic for the 1st time*, Titre Blood Tests are mandatory. For students/instructors returning to clinic for a 2nd year titre blood tests *do not* have to be repeated, **but results and lab reports must be resubmitted**. Please attach copy of immunization record.

	Date:	Results:	Booster Vaccine *(if needed)*
Hemoglobin & Hematocrit	__/__/__		
Routine Urinalysis	__/__/__		
Rubeola Titre	__/__/__		
Rubella Titre	__/__/__		
Mumps Titre	__/__/__		
Varicella Titre	__/__/__		

Examining Physician's Statement: The above named student can assume, without any limitations, classroom and clinical assignments. He/she is free at this time for any habituation or addition to alcohol or drugs that may be a potential risk to Hospital Patients or Nursing Home residents.

Physician Signature and Stamp	
Physician Name (print) :	Date:
Street Address:	
Telephone:	

Attach Lab Results: ○ Rubeola Titre ○ Rubella Titre ○ Mumps Titre ○ Varicella Titre ○ Documentation of booster immunization (only for low immunity titres) ○ Chest X-Ray (only if positive PPD result)