

William Paterson University

Health Record: Initial Physical Exam for Clinical Clearance

Patient Name: _____ Student ID#: 855_____

DOB: _____ Age: _____

Allergies: _____

Medications: _____

Past Medical History: _____

1. Physical Examination (to be filled out by provider)

HT _____ WT _____ LMP _____

BP _____ HR _____ RR _____ Temp _____

Vision Screen: OD ____/____ OS ____/____ With / Without Correction

Color testing: Pass / Fail

	WNL	Abnormal/Comments
General		
Skin		
Nodes		
HEENT		
Mouth		
Chest/Breast		
Lungs		
Heart		
Abdomen		
Gent/Rect		
Extrem/Hips		
Back/Spine		
Muscoskeletal		
Neuro		

2. Assessment:

Student is medically cleared to participate in the clinical setting: Yes No

If no, explain: _____

MD/NP/PA Signature

Date

(Continued on next page)

Name: _____ DOB: _____

3. Tuberculosis Screening-

Mantoux Test If step one is negative repeat same dose for step two 1-3 weeks after initial test.

(Initial) Step One Date: _____ Result: _____ mm
Step Two Date: _____ Result: _____ mm

(Annual) Date: _____ Result: _____ mm

Interpretation of Mantoux according to "at risk" status of individual tested, i.e.: 5mm, 10mm, 15mm may require follow up (June 2000 CDC guidelines). If positive see below:

CRX Date: _____ Results: Negative/Positive _____

Prophylaxis/Treatment History. Include date started and end date:

If treatment is not recommended give reason. Also include any precautions and follow-up instructions: _____

4. CBC A Complete Blood Count must be done (within one year) and *report attached*.**5. Proof of Immunity (By titer only)** *Attach copy of lab titer results.*

If a student receives a negative/equivocal titer for MMR or Varicella he/she is required to have the MMR or Varicella vaccine

Titer Dates:

Measles (Rubeola) Date: _____ Immune / Non-immune MMR Booster _____**Mumps** Date: _____ Immune / Non-immune**Rubella** Date: _____ Immune / Non-immune**Varicella** Date: _____ Immune / Non-immune Varicella Booster _____**6. Hepatitis B** Dates of Immunization:

Dose #1 _____ Dose #2 _____ Dose #3 _____

OR

Positive Antibody (HbsAB) Date: _____ *Attach copy of lab titer results.***7. Tetanus Booster.** You need proof of a Tetanus booster within the last 10 years.Booster Date: _____ *Please attach documentation.**Tetanus vaccine is available at The Health Center for \$20 per vaccine w/appointment*

Provider's Stamp (Required)