DYOUVILLE

PHYSICAL ASSESSMENT/ CERTIFICATION FOR CLINICAL AND/OR FIELD PLACEMENT

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

STUDENT TO COMPLETE THE FOLLOWING:

HEALTH INSURANCE COVERAGE

COMPANY NAME:_____ **POLICY NUMBER**:_____ **GROUP NUMBER:** _____

STUDENT EMAIL:_____ **STUDENT CELL PHONE**: _____

ACADEMIC PROGRAM: _____

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

Date of Exam: _____/_____/_____

Height:_____ Weight:_____

BP:_____ Pulse: _____

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

CHECK EACH ITEM IN PROPER COLUMN:

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 _____

DOES THE STUDENT HAVE ANY LIMITATIONS THAT WILL IMPACT THE ABILITY TO FULLY PARTICIPATE IN CLINICAL AND/OR FIELD PLACEMENT EXPERIENCES?

☐ NO LIMITATIONS

☐ YES, LIMITATIONS INCLUDE: _____

_____

REQUIRED SIGNATURE

_____ Date:_____/_____/_____

HEALTH CARE PROVIDER'S SIGNATURE

PRINT OR STAMP HERE _____

ADDRESS:_____ PHONE: _____

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

IMMUNIZATION RECORD

COPIES OF ALL TITERS MUST **ACCOMPANY THIS DOCUMENT**

Titer is only required if dates of required vaccination are not available.

Per CDC guidelines, documentation of appropriate vaccination doses is evidence of immunity.

** Clinical sites may require additional health documentation for student to participate in clinical and/or field placement.*

1. **TUBERCULOSIS (TB) CLEARANCE (ANNUAL) - PPD *OR* QUANTIFERON GOLD**

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

(If required by site) **2ND PPD:** Date placed:____/____/____ Date Read:__/____/____Reaction (mm) _____

** **(If PPD is positive, a chest X-ray must be obtained and** a **copy of the report must** accompany this document.)*

CHEST X-RAY: ____/____/____ RESULTS: _____

OR

QUANTIFERON GOLD: Date of blood test:____/____/____ RESULTS:_____Copy of blood work required.

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]

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.

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.

10. **COVID VACCINE** Manufacturer _____ 1st dose: ____/____/____ 2nd dose:____/____/____

Lot #: _____ Lot #: _____

REQUIRED SIGNATURES

_____ Date:____/____/____

HEALTH CARE PROVIDER'S SIGNATURE

PRINT OR STAMP HERE _____

ADDRESS:_____PHONE: _____

I am aware and understand that in order to maintain the health and safety of clients and meet designated health laws, agencies used for clinical and/or field placement experiences may require selected information from my health record. I authorize release of this document to said agencies and to the program office. I also concur that the information above, attested to by my health care provider, is true.

_____ Date:____/____/____

STUDENT'S SIGNATURE