Delhi
STATE UNIVERSITY of NEW YORK

Student's Name _____

Date of Birth _____

PHYSICAL EXAMINATION

To the Examining Practitioner:

Please review the student's history and complete applicable parts of the examination form.

1 Height _____ 2 Weight _____ 3 Blood Pressure _____ / _____ 4 Pulse _____

5 Vision Right 20/ Corr. 20/
Left 20/ to 20/

Describe any abnormalities of the following systems in the space below.

	Normal	Abnormal
6 Head, Ears, Nose, or Throat		
7 Eyes (with Ophthalmoscope)		
8 Hearing		
9 Neck-Thyroid		
10 Respiratory		
11 Cardiovascular		
12 Gastrointestinal		

	Normal	Abnormal
13 Hernia		
14 Genitourinary		
15 Musculoskeletal		
16 Metabolic/Endocrine		
17 Neuropsychiatric		
18 Skin		

	Yes	No
19 To the best of your knowledge, is this person free from physical or mental impairments, including alcohol or drug dependency?		
20 Are there any restrictions of physical activity indicated by your examination? Comment if "Yes."		
21 Is the patient now under treatment for any medical or emotional condition? Comment if "Yes."		
22 Do you have any recommendations regarding the care of this student? Comment if "Yes."		
23 **Public health regulations require that hospitals ensure that their personnel are "free from a health impairment, which is of potential risk to the patient or which might interfere with the performance of his or her duties" 10 NYCRR 405.3(b)(10). Student meets this requirement? Comment if "No."**		
24 How long and in what capacity have you known this student?		

IMMUNIZATION HISTORY

IMMUNIZATIONS REQUIRED	Dates of Injections
IF DATE OF BIRTH IS PRIOR TO 1/1/57, ANSWER 29-43	
IF DATE OF BIRTH IS AFTER 1/1/57, ANSWER 25-43	
Two Measles Vaccines Required	
25 MMR-MEASLES/MUMPS/RUBELLA (TWO) OR:	
26 MEASLES VACCINE (TWO IMMUNIZATIONS)	
27 MUMPS VACCINE	
28 RUBELLA VACCINE	
29 TETANUS OR TD WITHIN 10 YEARS	
30 POLIO ❑ SALK ❑ SABIN	
IMMUNIZATIONS STRONGLY RECOMMENDED	Dates of Injections
31 HEPATITIS B (SERIES OF 3 INJECTIONS)	
32 INFLUENZA	
33 MENINGOCOCCAL VACCINE	
34 HEPATITIS A	
35 HPV VACCINE	
36 TDAP (TETANUS DIPHTHERIA ACELLULAR PERTUSSIS)	
37 OTHER:	

TITERS/LAB REPORTS REQUIRED (attach copies) LAB REPORT **MUST** INCLUDE INDEX/VALUES	Date	Pos	Neg
38 Measles Titer (Rubeola)			
39 Mumps Titer			
40 Rubella Titer (German Measles)			
41 Varicella Titer (Chicken Pox)			
42 Hepatitis B Titer (unless declination is signed below)*			
43 PPD Tuberculosis Mantoux within 6 months mandatory (if test is positive, chest x-ray is required) Date _____ _____mm			
44 Chest x-ray (if positive PPD attach report) Date _____ _____ mm Place _____ Result _____ Treatment _____			
45 BCG VACCINE Date _____ NA _____			

Examining Practitioner Signature _____ **Date of Examination** _____

Print Practitioner's Name _____ **Telephone No. (include area code)** (____) _____

Address _____ **Zip** _____