NEW YORK INSTITUTE OF TECHNOLOGY
SCHOOL OF HEALTH PROFESSIONS DEPARTMENT OF NURSING

HEALTH EVALUATION FORM

NAME: _____ **Student#**: _____ **DATE**: _____

YR: First semester JR: _____ Second semester JR: _____ First semester SR: ____ Second semester SR: _____

I am a Northwell employee: Yes ☐ No ☐

ADDRESS: _____ **City**: _____ **State**: _____ **ZIP**: _____

TELEPHONE: _____ **DOB**: _____

ALLERGIES: _____

MEDICAL HISTORY

PAST MEDICAL HISTORY: _____ NONE: _____

PAST SURGICAL HISTORY: _____ NONE: _____

MEDICATIONS: _____ NONE: _____

PHYSICAL EXAMINATION

General_____Normal Comments: _____

HEENT_____Normal Comments: _____

Neck _____Normal Comments: _____

Lungs _Normal Comments: _____ Abdomen _____

_____Norma Comments: _____ Extremities _____

_____Normal Comments: _____

VITAL SIGNS:

Pulse: _____ Height: _____Respirations: _____ Weight: _____BP: _____Temperature: ___

I certify that this student is immune to (please attached titer laboratory reports to this attestation):

- ☐ Measles
- ☐ Mumps
- ☐ Rubella
- ☐ Varicella
- ☐ Hepatitis B

If lab titers cannot demonstrate the student's immunity to the above diseases, please describe the plan for this student here:___

Student's Name: _____

LAST TETANUS VACCINATION: _____

FIRST PPD:

PPD TYPE: _____ DATE PLACED: _____ DATE: _____

READ: _____ NEGATIVE: _____ POSITIVE: _____

MM: _____

SECOND PPD:

PPD TYPE: _____ DATE PLACED: _____ DATE: _____

READ: _____ NEGATIVE: _____ POSITIVE: _____

MM: _____

or

QUANITFERON GOLD result: _____

or

CHEST X-RAY DATE: _____ RESULTS: _____COMMENTS: _____

☐ **I certify that this student has no medical restrictions with would preclude him or her from participation in any school or hospital activities. The student may participate in all activities without restrictions.**

Comments:

Health Provider Signature: _____

Physical Exam Performed By: _____Title: _____License#: _____Date:_____

_____

Student Signature: _____

Reviewed/Revised –5/24/22