Stony Brook University School of Nursing
Health Sciences Center

STUDENT ANNUAL PHYSICAL EXAMINATION

SON Program Code: _____
(Official use only)

Student Name: _____ SBID: _____

Address: _____

Date of Birth: _____ Telephone: _____

Health Sciences Center students who receive education in clinical settings must obtain an annual physical examination following the requirements of Stony brook university Hospital and other clinical affiliates. Students must be examined by a licensed healthcare provider.

To Be Completed By Practitioner:

Height _____ Weight_____ B/P _____ Pulse: _____

Yes	No	PLEASE ATTACH ANY NECESSARY COMMENTS
		1. Has there been any significant medical illness or injury in the last 12 months? Describe?
		2. Is the student receiving medication on a continuing basis and/or under a MD/NP/PA care for continuing medical problem(s)? Describe?
		3. Is the student allergic to any medications? Or materials? (i.e. latex) Describe?
		4. PPD (required yearly) Date: Neg. Pos. Size of Induration: If positive PPD, chest x-ray required: (x-ray must be dated within 2 years) Date: Place: Results: If positive chest x-ray attach report. NOTE: Students with positive PPD and/or positive chest x-ray will be referred to Student Health Service for follow up as appropriate.
		5. Tetanus or TD (within 10 years) Date of last immunization:
		6. To the best of your knowledge, is this person free from physical or mental impairments including alcohol and/or drug dependency?
		7. Are there any restrictions of physical activity indicated by your examination? Comment?
		8. Is the student now under treatment for any medical or emotional condition? Comment?
		9. Do you have any recommendation regarding the care of this student? Comment?
		10. Public health regulations requires that hospitals ensure that their personnel are "free from a health impairment which is 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?

How long and in what capacity have you known this student? _____

Practitioner Signature: _____ **Date:** _____

Print Name/Address/Telephone: _____

Return to: Stony Brook University School of Nursing
Office of Student Affairs
Stony Brook, New York 11794-8240

Must submit Annually

q:student/forms/annual healthform Nov 2013