HELENE FULD COLLEGE OF NURSING

24 East 120th Street
New York, New York 10035
(212) 616-7200 Fax: (212) 616-7297

DUE DATE

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ADMISSION PHYSICAL ASSESSMENT FORM

Part A must be completed by Student

LAST NAME ________________________________ **FIRST NAME** ________________________ ______

DATE OF BIRTH _____________________________ **PHONE** __________________________________

ADDRESS____

CITY____ **ZIP CODE**____________________________

DECLINATION STATEMENT

If Hepatitis B titer is negative:

I understand that due to my exposure to potentially infections materials in clinical arrears, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have declined Hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B.

______________________________ ______________________________
SIGNATURE DATE

THIS SECTION IS TO BE COMPLETED AND SIGNED BY STUDENT

MENINGOCOCCAL (One dose within 10 years recommended by NYS PHL § 2167)

See fact sheet(Page 4)

CHECK ONE (1) BOX ONLY

- ❑ Quadrivalent polysaccharide vaccine (MenomoneTH) within the past 10 years.

  Date received____

- ❑ I Have read, or have had explained to me, the information regarding meningococcal meningitis disease. I will obtain immunization against meningococcal meningitis **within 30 days** from my private health care provider.

- ❑ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risk of not receiving the vaccine. I have decided that I will **not** obtain immunization against meningococcal meningitis disease.

Student Signature: ____ Date: ___________________

**ALL TITERS AND LAB REPORTS MUST BE XEROXED AND ACCOMPANY THIS FORM.
PLEASE SUBMIT 4 SET OF COPIES -- MEDICAL FORMS AND LAB REPORTS.**

Physical or Nurse Practitioner Evaluation/Review of Systems and History:
Part B must be completed by Physician

Date of Physical Exam_____________________________________

Head/Neck: ____ Skin: _____________________________________

Respiratory: ____ ENT: _____________________________________

Neurological: ____ Endocrine: _________________________________

GI/Abdomen: ____ Cardio-Vascular: ____________________________

Muscular/Skeletal: ____________________________________ GYN: _____________________________________

Allergies: ____ Medications: ______________________________

Past Illnesses/Injuries:____

Current Illnesses/Injuries: ____

Smoking: Yes:__________ No:__________ How Often?____

Alcohol: Yes:__________ No:__________ How Often?____

Drugs: Yes:__________ No:__________ How Often?____

HT:____________ WT:___________ BP:__________ P:____________ R:____________ T:_____________

Comments:____

Tetanus and Diphtheria Booster: Date:________________________ *** within past 10 years**

Rubella Titer
Rubeola Titer
Mumps Titer
Varicella Titer
Hepatitis B Titer

THESE TITERS **MUST** BE SUBMITTED ON LABORATORY **PRINTOUT ONLY**. IF NOT IMMUNE TO ANY OF THESE DISEASES, DOCUMENTATION OF A BOOSTER RECEIVED NO MORE THAN 10 YEARS AGO MUST BE SUBMITTED.

Vaccination Dates 1. ______________________ 2. _____________________ 3. ________________________

C.B.C
V.D.R.L. (R.P.R)
URINALYSIS

C.B.C. V.D.R.L. (R.P.R) AND URINALYSIS MUST BE CURRENT OR WITHIN THE LAST 6 MONTHS. SUBMIT LABORATORY PRINTOUT ONLY.

This person (IS, IS NOT) Physically and mentally capable of performing the functions of a nursing student, and (IS, IS NOT) free from any condition or communicable disease which would endanger his/her safety or the safety and well being of the patient/client/resident to be cared for.

PHYSICIAN/NURSE PRACTITIONER CERTIFICATION

Physician's Name (print): ___________________________ Signature: _________________________________

Address: ____ Telephone Number: _______________________

____ Date: _____________________________________

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Tuberculin Skin Test Record

Student's Name____

Date Administered____

Administered by____

Location

__________________Left Forearm __________________Right Forearm

Results

Date____________________________________

____________Negative ___________Positive ______________MM Indurations

Read by____

PPD must be current or within the last **6 months**.

If **PPD** is positive or if you received **BCG** and cannot take a **PPD** test, a radiology printout **must** be submitted indicating a **Chest X-Ray** has been taken within last year.

MENINGOCOCCAL DISEASE FACT SHEET

New York State Department of Health – Bureau of Communicable Disease Control

What is meningococcal disease?
Meningococcal disease is a severe bacterial infection of the bloodstream or meninges (a thin lining covering the brain and spinal cord).

Who gets meningococcal disease?
Anyone can get meningococcal disease, but it is more common in infants and children. For some college students, such as freshmen living in dormitories, there is an increased risk of meningococcal disease. Between 100 and 125 cases of meningococcal disease occur on college campuses every year in the United States; between 5 and 15 college students die each year as result of infection. Currently, no data are available regarding whether children at overnight camps or residential schools are at the same increased risk for disease. However, these children can be in settings similar to college freshmen living in dormitories. Other persons at increased risk include household contacts of a person known to have had this disease, and people traveling to parts of the world where meningitis is prevalent.

How is the germ meningococcus spread?
The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person. Many people carry this particular germ in their nose and throat without any signs of illness, while others may develop serious symptoms.

What are the symptoms?
High fever, headache, vomiting, stiff neck and a rash are symptoms of meningococcal disease. Among people who develop meningococcal disease, 10-15% dies, in spite of treatment with antibiotics. Of those who live, permanent brain damage, hearing loss, kidney failure, loss of arms or legs, or chronic nervous system problems can occur.

How soon do the symptoms appear?
The symptoms may appear two to 10 days after exposure, but usually within five days.

What is the treatment for meningococcal disease?
Antibiotics, such as penicillin G or ceftriaxone, can be used to treat people with meningococcal disease.

Is there a vaccine to prevent meningococcal meningitis?
Yes, a safe and effective vaccine is available. The vaccine is 85% to 100% effective in preventing four kinds of bacteria (serogroups A, C, Y, W-135) that cause about 70% of the disease in the United States. The vaccine is safe, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to 2 days. After vaccination, immunity develops within 7 to 10 days and remains effective for approximately 3 to 5 years. As with any vaccine, vaccination against meningitis may not protect 100% of all susceptible individuals.

How do I get more information about meningococcal disease and vaccination?
Contact your family physician or your student health service. Additional information is also available on the websites of the New York State Department of Health, www.health.state.ny.us; the Centers for Disease Control and Prevention www.cdc.gov, and the American College Health Association, www.acha.org.