Samford University
College of Health Sciences

PHYSICAL EXAMINATION

Program of Study ________________________

SUID # _________________________________

____ **SEX:** M ____ F ____

LAST NAME **FIRST NAME** **MIDDLE** **BIRTH DATE**

Blood Pressure ______________ Pulse __________ Height _________ Weight ________ lbs. Vision _______right ______left

____

The College of Health Sciences (CHS) requires that all students have evidence of a physical examination from a physician, physician's assistant, or nurse practitioner verifying that the individual is able to meet physical and mental requirements – with or without accommodation – for both didactic and clinical components of their respective program. The physical examination must be completed and this form submitted before the first day of class and annually thereafter. The student affirms that by submitting this form he or she consents to the disclosure of the information contained herein to the program, school and college's administrators, faculty and staff, as well as experiential site preceptors/coordinators as is necessary to ensure compliance with program requirements and affiliated site requirements.

REVIEW OF SYSTEMS:
Are there abnormalities in the following systems? Describe fully, including any assistive devices which may be required (e.g. hearing aids, eyeglasses, prosthetics, etc.).

	NO	YES	Comments
HEENT			
Respiratory			
Cardiovascular			
Gastrointestinal			
Musculoskeletal			
Neurologic			
Dermatologic			

ALLERGIES: ____

Is the patient now under treatment for any medical or psychological condition? NO_____ YES _____ (explain) __________
____

Does this patient have any active prescriptions, even if for occasional use only? NO______ YES _____ (list) _____________
____

Has this patient ever been diagnosed with alcoholism or another drug dependency (not including tobacco)? NO _____ YES _____ (list) _____________
____

Are there any conditions, physical and /or psychological, which may interfere with functioning as a health professional student in the classroom or clinical setting? NO _____ YES _____ (please comment)
____

NOTES/COMMENTS:____
____

Healthcare Professional's Name/Credentials: ____
Address: ____
City: ______________________________________ State: ____________________________ Zip: _________________

SIGNATURE OF PROVIDER:____ DATE:__________________________

***Veterans: Your Discharge Physical is Acceptable**

Samford University
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GRADUATE NURSING IMMUNIZATION RECORD

Name:____ **SU ID:** 9______________________
Last *First* *MI*

Email address: ______________________________ **Date of Birth:**_______/_______/________

Phone number: (____)______-_________

Enrolling: ☐Fall ☐Spring ☐Summer of **Year** 20___ **Program of Study:** ______________________________

Immunization history must be completed and signed by a health care provider
OR
Upload original immunization records directly to ESS at www.es2.com

VACCINATIONS REQUIRED

M.M.R. (Measles, Mumps and Rubella)

Born before 1957, no MMR immunization required

Combined Vaccines (Two doses; at least one month apart)

M.M.R (Measles,Mumps,Rubella)	#1 ____/____/_____ month/ day/ year	#2 ___/___/____ month/day/yea r

OR

Individually Administered Vaccines

Measles	#1 ___/____/______ month/day/year	#2 ____/____/____ month/day/year
Mumps	#1 ___/____/______ month/day/year	
Rubella	#1 _____________ month/day/year	

OR

Laboratory Evidence of Immunity (all 3 required) in lieu of vaccines
*must submit copy of lab report
*if not immune, please complete the vaccination series

Measles	#1 ___/____/______ month/day/year	Result: Immune or Non-Immune
Mumps	#1 ___/____/______ month/day/year	Result: Immune or Non-Immune
Rubella	#1 ___/____/______ month/day/year	Result: Immune or Non-Immune

Tdap (TETANUS-DIPHTHERIA-ACELLULAR PERTUSSIS)

At least one dose required within the last 10 years	_____/______/______ month/ day/ year

VARICELLA (Chickenpox)

History of Disease	___/___/___ Month Day Year (Minimum Month/Year as date accepted) please provide laboratory evidence of immunity if date not available)

OR

Immunizations (Two doses required)	#1 ___/___/___ Month Day Year	#2 ___/___/___ Month Day Year

OR

Laboratory Evidence of Immunity*
___/___/___ Month Day Year
RESULT: [ ] Immune [ ] Non-Immune

*must provide copy of lab report
*if not immune, please complete the vaccination series

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GRADUATE NURSING IMMUNIZATION RECORD

Page 2 of Patient ____
LAST *FIRST* *MI*

VACCINATIONS REQUIRED

INFLUENZA (required between September and August)

Immunization	/ / Month Day Year
	______

HEPATITIS B

Laboratory Evidence of Immunity in lieu of vaccines
*must submit copy of lab report
*if not immune, please complete the vaccination series

#1	#2 (at least one month after dose #1)	#3 (at least six months after dose #1 OR four months after dose #2)
/ / Month Day Year	/ / Month Day Year	/ / Month Day Year

OR

Hepatitis B Surface Antibody *(*must provide copy of lab report)*	/ / Month Day Year	RESULT: [ ] Immune [ ] Non-Immune

THIS SECTION TO BE FILLED OUT BY HEALTH CARE PROVIDER ONLY (within 6 months of entrance)

Student Health Information

□ Please list any potential communicable illnesses: ____

____

____

____

MD/PA/NP Signature: ______________________________ Date:______________ within 6 months of entrance

Print Name: ______________________________ Phone: (_____) ______-______________

Address: ____

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GRADUATE NURSING IMMUNIZATION RECORD

Patient ____
LAST *FIRST* *MI*

TUBERCULOSIS SCREENING:

The Ida Moffett School of Nursing at Samford University requires a two-step Tuberculosis (TST) PPD skin test, with a chest x-ray follow-up only after a positive PPD skin test, **OR** an IGRA blood test for all graduate nursing students. If you have received BCG vaccine, an IGRA test is preferred. If you have a history of a positive TST (PPD) ≥10mm or IGRA please supply information regarding any evaluation and/or treatment below. **You only need to complete one section.** Guidelines are based upon the recommendation of the CDC and the American College Health Association.

The two-step TB test must be administered between one (1) and three (3) weeks apart.

Section A		**Date Placed**	**Date Read**	**Reading**
Negative Skin Test or Blood Test	TST #1	_____/____/______	_____/____/______	_____ mm
	TST #2	_____/____/______	_____/____/______	_____ mm
	IGRA Blood Test	_____/____/______ _____/____/______	☐ T-spot ☐ Quantiferon Gold	☐ Attach copy
OR				
Section B		**Date Placed**	**Date Read**	**Reading**
History of Latent Tuberculosis, Positive Skin Test, or Positive Blood Test	Positive TST	_____/____/______	_____/____/______	_____ mm
	Positive IGRA Blood Test	**Date**	**Type Test**	
		_____/____/______	☐ T-spot ☐ Quantiferon Gold	☐ Attach copy
	Chest X-ray	_____/____/______	☐ Attach copy	
	Prophylactic medications for latent TB taken?		☐ Yes ☐ No	
	Total duration of prophylaxis?		______ months	
	Date of last annual TB symptom questionnaire (if applicable)		_____/____/______	
OR				
Section C				
History of Active Tuberculosis	Date of Diagnosis		_____/____/______	☐ Attach copy
	Date Treatment Completed		_____/____/______	☐ Attach copy
	Date of last annual TB symptom questionnaire (if applicable)		_____/____/______	☐ Attach copy
	Date of last Chest X-ray		_____/____/_____	☐ Attach copy

MD/PA/NP Signature: ____________________________________ Date:__________________ within 6 months of entrance

Print Name: ____________________________________ Phone: (_____) ______-_________________

Address: ____

Immunization history must be completed and signed by a health care provider
OR
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