HEALTH STATUS REPORT

Completion of this document and all additional documentation is required for a complete application.

The physical exam form must be filled out and signed by a Health Care Provider (Physician, Nurse Practitioner, or Physician Assistant).

- Laboratory results with numeric lab values is required for all titres read. Please submit lab results, and/or vaccination records as supporting documentation.
- A copy of your physical examination is required. This must be signed by a Health Care Provider. This examination must be within 12 months of your examination date.
- Immunization record must be signed by the student. Supporting documentation must be submitted to verify all information on the immunization record.
- If you require an accommodation or adjustment for the examination under the Americans with Disabilities Act, please contact our Accessibility Services office at ASC@excelsior.edu. For additional information, please visit: excelsior.edu/support-resources/accessibility-services.

If you are updating information, please submit a clean form with the updated information. If you are updating your physical, you will need to have the signature of the Health Care Provider on the updated form.

PHYSICAL EXAMINATION (Completed by health care provider)

Date of Physical Exam:

STUDENT NAME: **STUDENT ID:**

Gender:	Blood Pressure:	Allergies:
Date of Birth:	Pulse:	
Height:		
Weight:		

CLINICAL EVALUATION (Check each item in proper column or enter **NE** if not evaluated)

System	Normal	Abnormal	Notes/Details
1. Neurologic			
2. Cardiac			
3. Respiratory			
4. Gastrointestinal			
5. Genitourinary			
6. Musculoskeletal			
7. Skin			

Additional Comments:

Clearance to care for patients across the life span: ☐ Yes ☐ No

Comments:

My signature confirms that I have examined the above named individual and found him/her to be in satisfactory physical condition to care for patients across the lifespan.

Signature of Heath Care Provider and Credential: _____

Name of Provider: _____ Phone: _____ Date: _____

(Print)

IMMUNIZATION RECORD (Completed by student)

STUDENT NAME: _____ **STUDENT ID:** _____ **Date of Birth:** _____

	Vaccine Date or Date of Positive Titre	Supporting Documentation
MMR COMBINED VACCINE If born after 1/1/57, two (2) doses of LIVE vaccine: #1 no more than four (4) days prior to first birthday, #2 at least 30 days after first dose. OR	Vaccines: **1.** *(date):* _____ **2.** *(date):* _____	*Please attach supporting documentation or lab results.*
MEASLES (2 doses required) Positive titre with numeric result or physician documentation of having the disease are acceptable in lieu of vaccine.	Titre: ☐ Positive ☐ Negative *(date):* _____ Vaccines: **1.** *(date):* _____ **2.** *(date):* _____	*Please attach supporting documentation or lab results.*
MUMPS (2 doses required) If born after 1/1/57, two (2) doses of LIVE vaccine given after first birthday. Positive titre with numeric result or physician documentation of having the disease are acceptable in lieu of vaccine.	Titre: ☐ Positive ☐ Negative *(date):* _____ Vaccines: **1.** *(date):* _____ **2.** *(date):* _____	*Please attach supporting documentation or lab results.*
RUBELLA (1 dose required) If born after 1/1/57, one (1) dose of LIVE vaccine given after first birthday. Positive titre with numeric result is acceptable in lieu of vaccine. Documented history NOT ACCEPTABLE for Rubella.	Titre: ☐ Positive ☐ Negative *(date):* _____ Vaccine: **1.** *(date):* _____	*Please attach supporting documentation or lab results.*
TETANUS/DIPTHERIA Titres not acceptable. Must have proof of vaccination within last 10 years.	Vaccine: **1.** *(date):* _____ *Must be within last 10 years.*	*Please attach supporting documentation or lab results.*
VARICELLA Two vaccines, or positive titre. Include dates and lab values.	Titre: ☐ Positive ☐ Negative *(date):* _____ Vaccines: **1.** *(date):* _____ **2.** *(date):* _____	*Please attach supporting documentation or lab results.*
HEPATITIS B Series of three (3) vaccines or positive titre required. If you decline the Hepatitis B vaccine you must sign the declination statement below.	Titre: ☐ Positive ☐ Negative *(date):* _____ Vaccines: **1.** *(date):* _____ **2.** *(date):* _____ **3.** *(date):* _____	*Please attach supporting documentation or lab results.*

PLEASE SIGN BELOW **ONLY** IF YOU ARE DECLINING THE HEPATITIS B VACCINE:

Hepatitis B Vaccine Declination

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease.

Signature: _____ *(date):* _____

ANNUAL TUBERCULOSIS SCREENING BCG, PPD, QuantiFERON or T-Spot Blood Test Supporting documentation required. ☐ Negative ☐ Positive	**BCG Vaccine:** *(date):* _____ *Please attach supporting documentation or lab results.* **PPD step 1:** *(date read):* _____ *Please attach supporting documentation or lab results.* **PPD step 2:** *(date read):* _____ *Please attach supporting documentation or lab results.* OR **QuantiFERON** or **T-Spot:** *(date):* _____ *Please attach supporting documentation or lab results.* *If positive or BCG:* Chest X-Ray: *(date):* _____

My signature verifies, to the best of my knowledge, that all above data is correct. I understand this information may be released to the clinical facility(s) where the graded activity is administered. If I encounter a change in my health status, I will notify the College as soon as possible before my exam.

Signature: _____ *(date):* _____

EFFECTIVE DATE: 4/15/2019