APPENDIX C

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

HEALTH EVALUATION FORM

NAME: _____ YR: _____ JR: _____ SR: _____

ADM#: _____ DATE: _____

ADDRESS: _____ APT.: _____ ZIP: _____

TELEPHONE: _____ SS#:_____ DOB: _____

IMMUNIZATION RECORD

VACCINATIONS	DATES	TITER DATE	RESULTS
MEASLES #1			
MEASLES #2			
MUMPS			
RUBELLA			
VARICELLA #1			
VARICELLA #2			
DIPHTHERIA/TETANUS			
HEPATITIS B #1			
HEPATITIS B #2			
HEPATITIS B #3			
Flu Vaccine			
Meningitis recommended			

PPD TYPE: _____ DATE PLACED:_____ DATE: _____

READ: _____ NEGATIVE: _____ POSITIVE: _____ MM: _____

CHEST X-RAY DATE: _____ RESULTS: _____

COMMENTS:

_____

MEDICAL HISTORY

PAST SURGICAL HISTORY: _____ NONE: _____

MEDICATIONS: _____ NONE: _____

ALLERGIES: _____

PHYSICAL EXAMINATION

General _____ Normal Comments: _____

HEENT _____ Normal _____

Neck _____ Normal _____

Lungs _____ Normal _____

Abdomen _____Normal _____

Extremities _____ Normal _____

Vital Signs:

Pulse: _____ Respirations: _____ BP: _____ Temperature: _____

Height: _____ Weight: _____

Comments:

Physical Exam Performed By: _____ Title: _____ License#: _____ Date: _____

Print Name: _____

I have reviewed the above findings and examination of the patient and find no medical limitations to clinical/lab rotations.

Signature: _____

Original Document September 2005
Reviewed/Revised 2015, 2019