City College of San Francisco / John Adams Campus

Vocational Nursing Program

Physical Examination and Immunization Report

1860 Hayes Street, San Francisco, CA 94117

Telephone: 415-561-1912

Name of applicant: (Last Name) _____ (First Name) _____

Address: _____

Street City State Zip

Home Phone: _____ Cell Phone: _____

Applicant Release of Medical Information: I, _____authorize the medical information on this form to be sent to the City college of San Francisco Vocational Nursing Program.

Signature: _____ Date: _____

Name of Health Care Provider: _____

Address: _____

Telephone#: _____

Name of Physician: _____ Telephone#: _____

Physician's Signature: _____ Date: _____

Physician's Address: _____

PHYSICAL EXAMINATION:

Head: _____

Ears: _____ Hearing: _____ Hearing Aid R _____ L _____

Eyes: _____ Visual Acuity R _____ L _____ With Glasses: R ____/____ L ____/____

Teeth _____ Throat: _____ Neck: _____

Chest _____ Breath sounds: _____ Heart Rate: _____ Murmurs: _____

Abdomen: _____ Blood Pressure: _____

Are there any current physical or mental health conditions that would in any way limit this applicant's ability to perform clinical nursing care? ☐ Yes ☐ No

If yes, please describe in detail: _____

_____

_____

What medications are currently prescribed for this applicant? _____

_____

Note: All blank areas have to be completed in ink.

IMMUNIZATION RECORD:

(1) TUBERCULOSIS:

Date of PPD skin test: Step 1: _____ Results: _____ Step 2: _____ Results: _____

Or

Date of Chest X-Ray: _____ Results: (Neg/Pos) _____

Or

Date of Quantiferon: _____ Results: (Neg/Pos) _____

Or

Date of B.C.G Immunization: _____ (Negative/Positive) _____

(2) POLIO VACCINE (If not previously immunized) Date: _____

(3) TDAP: Date: _____

Or booster if not done within 10 years Date: _____

(4) MMR and PROOF of IMMUNITY:

Titre: _____ Immunization Date: _____ Immunity: (Neg/Pos) _____

Measles: (Negative/Positive) _____

Mumps: (Negative/Positive) _____

Rubella: (Negative/Positive) _____

(5) HEPATITIS B

Disease of Hepatitis B serum antibody titer verifying immunity.

Date: _____ Titer level: (Neg/Pos) _____

And

Dates of 3 Hepatitis B vaccinations. #1: _____ #2 _____ #3 _____

(6) VARICELLA (Negative/Positive)

Varicella serum antibody titer verifying immunity: (Neg/Pos) _____ Date: _____

And

Dates of Vaccinations: #1 _____ #2. _____

(Vanvax 4-8 weeks is recommended)

(7) SEASONAL FLU SHOT: Date: _____

Note: All blank areas have to be completed in ink.