HOFSTRA NORTHWELL
SCHOOL of NURSING
AND
PHYSICIAN ASSISTANT STUDIES

ANNUAL HEALTH ASSESSMENT

TO BE COMPLETED **BY HEALTH CARE PROVIDER AND STUDENT**

SEMESTER: _____

YEAR: _____

Last Name:_____First Name:_____Date of Birth: _____

Hofstra ID#:_____Program Type & Year: _____

Hofstra Email Address:_____Personal Email Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

I hereby authorize Hofstra University to release my information below to any health care provider which may require same in connection with my participation in a clinical course. I understand the agency to which I am assigned may require more health data than listed below.

Signature:_____Date: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER: (MUST FILL OUT ALL 5 PARTS)

A thorough examination was performed on the above-named individual. The following was assessed:

Part 1: Complete History and Physical Examination (Required Annually) Date: _____

Part 2 (Only to be Completed by Non Northwell Health Employees):

PPD (Mantoux) [Required annually when negative; **OR** completion of blood based Tb Screen] Date Placed: _____ Date Read: _____

Induration (mm.):_____Interpretation (circle one): Negative Positive

Blood based TB Screen (i.e.QuantiFERON-TB Gold; T-Spot.TB) **Interpretation (circle one): Negative Positive**

(NOTE: PPD requirement must be met regardless of BCG vaccination history)

In the case of a positive PPD, please complete the attached Tuberculosis (TB) Screening Form. Your health care provider must follow the guidance from the NYS Department of Health and provide the appropriate Tuberculosis screening form to complete this portion of your health clearance

Part 3: Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine (Tdap) (one dose required) Date: _____

Part 4: Flu Vaccine Recent Date: _____

If declined the Flu Vaccine evidence of declination form* Yes: _____ No: _____

Part 5: Respiratory Fit Testing Date _____ Copy Attached ☐

I find him/her to be in good health. He/she is free from a health impairment which may pose potential risk to patients or personnel, or which may interfere with the performance of nursing responsibilities.

YOUR SIGNATURE INDICATES THE INDIVIDUAL IS ABLE TO FULLY PARTICIPATE IN NURSING PRACTICE.

SIGNATURE of **Examining Certified Nurse Practitioner or Physician Assistant or Physician** _____

Date: _____

(STAMP IS NOT ACCEPTABLE IN PLACE OF SIGNATURE)

Print or Type Name
Office or Agency
Address (Required)
Telephone Number (Required)

STAMP HERE

***If declined the Flu Vaccine, the student is required to wear a mask in the clinical setting**

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Respirator Medical Evaluation Questionnaire

Please include a phone number where you can be reached by the health care professional who reviews the questionnaire:

Area Code: ( ) _____- _____

Indicate the best time to phone you at this number:_____ AM / PM

PLEASE PRINT:

Today's Date: Month: _____ Day: _____ Year: 20 ____

Your Name: (First)_____(Last) _____

Job Title:_____**N/A**_____Dept./Division:_____**N/A**_____

Home Phone number:_____Email Address: _____

Date of Birth_____/_____/_____ Age (to nearest year): _____

Sex: Male___Female___ Height:_____Weight:_____lbs.

Have you ever completed the FIT Testing process in the past as an employee, student or volunteer? Yes___No___

If you are not sure of an answer below, you may leave it blank.

1. Check the type of respirator you will use (if applicable, you can check both "a" and "b"):

   a. _____ N, R, or P. disposable respirator (filter-mask, non-cartridge type only).

   b. _____ Other type (for example, half-or full facepiece type, powered air purifying, supplied air, self-contained breathing apparatus).

2. Have you worn a respirator (check one): Yes___No___

   If "yes", indicate what type(s):_____.

Questions 1 through 9 must be answered by every student who has been selected to use any type of respirator. Please check "yes" or "no":

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?

YES	NO

2. Have you had any of the following conditions:

	YES	NO
a. Seizures (fits):		
b. Diabetes (sugar disease):		
c. Allergic reactions that interfere with your breathing:		
d. Claustrophobia (fear of closed-in places)		
e. Trouble smelling odors		

3. Have you ever had any of the following pulmonary or lung problems:

	YES	NO
a. Asbestosis:		
b. Asthma:		
c. Chronic Bronchitis		
d. Emphysema:		
e. Pneumonia:		
f. Tuberculosis		
g. Silicosis:		
h. Pneumothorax (collapsed lung):		
i. Lung Cancer:		
j. Broken ribs:		
k. Any chest injuries or surgeries:		
l. Any other lung problems that you've been told about		

4. Do you currently have any of the following symptoms of pulmonary or lung illness:

	YES	NO
a. Shortness of breath:		
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline		
c. Shortness of breath when walking with other people at an ordinary pace on level ground:		
d. Have to stop for breath when walking at your own pace on level ground		
e. Shortness of breath when washing or dressing yourself:		
f. Shortness of breath that interferes with your job:		
g. Coughing that produces phlegm (thick sputum):		
h. Coughing that wakes you early in the morning:		
i. Coughing that occurs mostly when you are lying down:		
j. Coughing up blood in the last month:		
k. Wheezing:		
l. Wheezing that interferes with your job:		
m. Chest pain when you breathe deeply:		
n. Any other symptoms that you think may be related to lung problems		

5. Have you ever had any of the following cardiovascular or heart problems:

	YES	NO
a) Heart attack:		
b) Stroke:		
c) Angina:		
d) Heart Failure:		
e) Swelling in your legs or feet (not caused by walking):		
f) Heart Arrhythmia (heart beating irregularly):		
g) High Blood Pressure:		
h) Any other heart problem that you've been told about:		

6. Have you ever had any of the following cardiovascular or heart symptoms:

	YES	NO
a) Frequent pain or tightness in your chest:		
b) Pain or tightness in your chest during physical activity:		
c) Pain or tightness in your chest that interferes with your job:		
d) In the past two years, have you noticed your heart skipping or missing a beat		
e) Heartburn or indigestion that is not related to eating:		
f) Any other symptoms that you think may be related to heart or circulation problems		

7. Do you currently take medication for any of the following:

	YES	NO
a) Breathing or lung problems:		
b) Heart trouble:		
c) Blood pressure:		
d) Seizures (fits):		

8. If you have never used a respirator, check the following space:_____,
and go to Question 9.

If you have used a respirator, have your ever had any of the following problems:

	YES	NO
a) Eye Irritation		
b) Skin allergies or rashes:		
c) Anxiety:		
d) General weakness or fatigue:		
e) Any other problem that interferes with your use of a respirator:		

	YES	NO
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?		

Student Signature:_____Date: _____

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Tuberculosis Screening Questionnaire

Name:_____ DOB: _____

Employee ID (if applicable): _____ Date: _____

Please circle Yes or No

1.) Do you have a history of positive Tuberculosis (TB) screening? **Yes** **No**

If yes, which test was positive?

D Tuberculin Skin Test (TST/PPD)
Month and Year of positive Test____/_____
Size of induration? ☐ ☐ mm

D Blood based TB Screen (i.e. QuantiFERON-TB Gold; T-Spot.*TB*)
Month and Year of positive Test____/____

2.) Were you born in the United States? **Yes** **No**

If no, what country were you born? _____
Year of immigration to the US? _____

3.) Have you received the BCG vaccine in the past? **Yes** **No**

4.) Have you ever taken or been advised to take medication for Tuberculosis because of a Positive TB Screening? **Yes** **No**

4a.) If medication was taken, please indicate what year it was taken and for how long.

Year:_____
Length:_____months

5.) Have you had a recent chest x-ray? **Yes** **No**

If yes, please attach results. (Must be within the last 12 months)

For individuals who have had a **Positive** reaction in the past to TST/PPD circle all that applies:

- Cough greater than 3 weeks Yes No
- Coughing up blood Yes No
- Loss of appetite Yes No
- Unexplained weight loss Yes No
- Night sweats Yes No
- Hoarseness Yes No
- Persistent Fever Yes No
- Weakness or fatigue Yes No
- Chest Pain Yes No

Signature_____ Date_____