Rockland Community College
STATE UNIVERSITY OF NEW YORK

Records & Registration

ANNUAL HEALTH REVIEW

This form must be filled out completely or it will not be accepted.

Name:_____
Last **First** **Middle**

Student ID #: _____ Cell Phone: _____

Email:_ _____@sunyrockland.edu

Date of Physical Exam: _____

Health Care Provider's Name: _____

Health Care Provider's Address: _____

Blood Pressure: _____ Pulse: _____ Weight: _____

Tuberculin Mantoux Test Date Placed: _____ Date Read: _____

Results: _____ mm: _____

(If the results are positive, a chest x-ray must be performed.)

Chest x-ray: Date: _____ Date Read: _____ Results: _____

I hereby state that I am free of any physical or mental health condition that may place me, patients, staff, faculty or other students at risk or that may limit my ability to function safely in the clinical area. I am aware that any change in my health status must be reported to Records & Registration and the Nursing Office immediately upon diagnosis.

Student's Signature: _____ Date: _____

HEALTH CARE PROVIDER RECOMMENDATION:

I have examined and determined that_____is free from any health impairment of potential risk to self, patients or staff which might interfere with the performance of his/her duties, including, but not limited to, the habituation or addiction to depressants, stimulants, narcotics alcohol or other drugs or "substances" which may alter behavior. He/she can engage without restriction in clinical activities that may include bathing, turning, lifting, positioning, transferring bed to chair/stretcher and back to bed of conscious and unconscious patients and assisting unsteady patients with ambulation.

_____ _____

Signature of Health Care Provider Date

Stamp of Health Care Provider

Name of Health Care Provider (please print): _____

Address: _____

Phone: _____