

Barry University
 College of Health Sciences
 11300 NE Second Avenue
 Miami Shores, FL 33161
 Phone (305) 899-3815
 Fax (305) 899-3831



Annual Physical Form

To be completed by a licensed health care provider.

I certify that _____ has been examined by me on ___/___/___ and is found to be in good physical and mental health, and appears able to undertake all aspects of the health education program with or without accommodation.

(Please see "Core Performance Standards for Admission, Progression, and Graduation" in the College of Health Sciences printed below.)

Practitioner's name (print): _____

Practitioner's signature: _____

Licensed as (check one): ARNP _____ Physician Assistant _____ Physician _____

License number: _____ State/Country licensed: _____

Core Performances Standards for Admission, Progression, and Graduation

Performance inclusive)	Standard	Examples of Necessary Activities (Not all
Critical Thinking	Critical thinking ability sufficient for clinical judgment	Identify cause-effect relationships in critical situations; develop nursing care plans.
Interpersonal	Interpersonal abilities sufficient to interact with individuals, families, and groups from a variety of social, emotional, cultural, and intellectual backgrounds	Establish rapport with patients/clients and colleagues.
Communication	Communication abilities sufficient for interaction with others in oral and written form	Explain treatment procedures, initiate health teaching, document and interpret nursing actions and patient/client responses. Give oral and written reports to other members of the health care team.
Mobility	Physical abilities sufficient to move from room to room and maneuver in small places	Move around in patient rooms, work spaces, and treatment areas, administer cardiopulmonary resuscitation procedures. Meet responsibilities in a timely manner.
Motor skills	Gross and fine motor abilities sufficient to provide safe and effective nursing care	Calibrate and use equipment; safely position, lift, and transfer patients/clients.
Hearing	Auditory ability sufficient to monitor and assess health needs	Hear monitor alarm, emergency signals, auscultatory sounds, cries for help.
Visual	Visual ability sufficient for observation and assessment necessary in nursing care	Observe patient/client responses at a distance and close at hand. Comprehend three-dimensional relationships and spatial relationships of objects.
Tactile	Tactile ability sufficient for physical assessment	Perform palpation, auscultation, percussion and functions of physical examination and/or those related to therapeutic intervention.
Social Behavior	Compassion, integrity, interpersonal skills, interest and motivation	Develop a mature, sensitive and effective relationship with clients.

The completed Annual Physical Form is to be received by the College of Health Sciences one (1) week before schools begins.

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IMMUNIZATION RECORD

To be completed by a licensed health care provider.

Student Name: _____

Date: ___/___/___ Date of Birth: ___/___/___ School ID # or Social Security # _____

THE FORM BELOW IS TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

All information must be in English. A copy of the original immunization record(s) is preferred.
The immunizations listed below are **REQUIRED** for all students, prior to starting clinical rotations.

M.M.R. (Measles, Mumps, Rubella) _____ Dose #1 ___/___/___ Dose #2 ___/___/___

(Two doses required at least 28 days apart for students born after 1956)

If given separately:

OR

Measles: Dose #1 ___/___/___ Dose #2 ___/___/___ OR Titer date and results ___/___/___ Immune Not Immune

Mumps: Dose #1 ___/___/___ Dose #2 ___/___/___ OR Titer date and results ___/___/___ Immune Not Immune

Rubella: Dose #1 ___/___/___ Dose #2 ___/___/___ OR Titer date and results ___/___/___ Immune Not Immune

*** (Must provide a copy of lab results with numerical result) ***

TETANUS-DIPHTHERIA (Booster with Td in the last ten years is required)

1. Booster: Tdap (preferred) to replace a single dose of Td for booster immunization at least 2-5 years since last dose of Td, depending on age of patient. (Administer with MCV4 simultaneously if possible)..... ___/___/___

2. Booster: Td within the last ten years..... ___/___/___

VARICELLA (either a history of chicken pox with a positive varicella antibody **OR** two doses of vaccine)

Varicella antibody date: ___/___/___ (Please attach lab results) Results: Immune Not Immune

Immunization:Dose #1 ___/___/___ Dose#2 ___/___/___

HEPATITIS B (Three doses of vaccine OR a positive Hepatitis B surface antibody OR complete attached waiver)

1. Immunization (Hepatitis B)

Dose #1 ___/___/___

Dose #2 ___/___/___

Dose #3 ___/___/___

2. Hepatitis B surface antibody

Date ___/___/___

Immune

Not Immune

*** (Must provide a copy of lab results with numerical result) ***

TUBERCULOSIS SCREENING

1. First PPD skin test

Date given ___/___/___ Date read ___/___/___

Result : ___ (Record actual mm of induration, if no induration, write "O")

2. Second PPD test

Date given ___/___/___ Date read ___/___/___

Result : ___ (Record actual mm of induration, if no induration, write "O")

3. Chest x-ray (**required if PPD skin test is positive**) ***required one time only - unless symptoms are present ***

Date of chest x-ray ___/___/___ Result: Normal ___ Abnormal ___

Symptom check list after first year Result: Normal ___ Abnormal ___

HEALTH CARE PROVIDER (Please sign and place health care provider address and phone number or stamp below.)

Name: _____ Signature: _____ Date: _____

Address: _____ Phone: _____