KINGSBOROUGH COMMUNITY COLLEGE
★ DREAMS BEGIN HERE ★

KINGSBOROUGH COMMUNITY COLLEGE
OF
THE CITY UNIVERSITY OF NEW YORK
2001 ORIENTAL BOULEVARD
BROOKLYN, NEW YORK 12235

DEPARTMENT OF NURSING FACULTY HEALTH RECORD

Faculty in the Department of Nursing is required to have a Physical Examination and Tuberculin Skin Test or Serum Quantiferon Gold every year.

Faculty Name: _____EMPLID.#_____

Address:_____ Date of Birth: _____

Home Telephone: _____

In case of emergency notify: _____Phone:_____

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1. **PHYSICAL EXAMINATION**
   I have examined the above and found him/her to be in satisfactory physical condition to care for child and adult clients in health care facilities.

   Yes_____ No _____

   List any ongoing or chronic conditions for which this individual is being treated
   _____
   _____
   _____

   List all medications taken regularly or which are prescribed for the above condition(s)
   _____
   _____
   _____

   Limitations, which prohibit the faculty member from providing care to child and adult clients should be documented by a physician who is a specialist in health problem identified.

2. **10-PANEL URINE DRUG SCREEN –** (attach copy of report)

3. TUBERCULIN TESTING

a. **Serum Quantiferon Gold**

or

b. **PPD**

The following results were obtained from tuberculin testing:

Positive_____ Negative_____

Date of testing: _____

POSITIVE TUBERCULIN TEST REQUIRES CHEST X-RAY

Chest x-ray results:_____
Date of x-ray:_____

4. RUBEOLA (measles) TITRE LEVEL (attach copy of report)

The resulting levels were:

Positive_____ Negative_____
**Immunization required: Date of Immunization

5. RUBELLA TITER LEVEL (attach copy of report)

The resulting levels were:

Positive_____ Negative_____
**Immunization required: Date of Immunization

6. MUMPS TITER LEVEL (attach copy of report)

The resulting levels were:

Positive_____ Negative_____
**Immunization required: Date of Immunization

7. VARICELLA TITER LEVEL (attach copy of report)

The resulting levels were:

Positive_____ Negative_____
**Immunization required: Date of Immunization

8. HEPATITIS B

Dates of Hepatitis B Vaccine: #1_____#2_____#3_____

or

Declination Statement_____

9. HEPATITIS C TITER LEVEL

The resulting levels were:

Positive_____ Negative _____

Pursuant to Section 405.3 (b) of the New York State Hospital Codes, the following Statement of Physical Examination is required:

Based on my physical examination and the patient's medical history, I believe that the above-mentioned individual is free from a health impairment which is of potential risk to patients or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

Signed_____

EXAMINING PRACTITIONER

NAME_____

ADDRESS_____

_____**ZIP**_____

TELEPHONE NO: (____)_____

DATE OF EXAMINATION_____

Release of Information:

I grant permission for this information to be released, if requested, to the clinical facility (s) assigned.

Signature of faculty member:_____

Revised Jan. 2021