# WAGNER COLLEGE

**Evelyn L. Spiro School of Nursing**

PHYSICAL ASSESSMENT/QUANTEFERON/URINE DRUGS SCREEN

**REQUIRED ANNUALLY**

☐ BS ☐ 15MONTH ☐MS ☐ DNP

| LAST NAME | FIRST NAME | Date of Birth | WAGNER ID |
|---|---|---|---|
| ADDRESS | CITY, STATE | ZIP | |
| GENDER IDENTITY<br>☐ Male ☐Female ☐Other | PHONE (cell) | Email | |

**DO NOT WRITE BELOW THIS LINE** **DO NOT WRITE BELOW THIS LINE**

**PART A: Complete History and Physical Examination**

| **DATE OF EXAM** | ALLERGIES: ☐NKDA LATEX ☐ YES ☐ NO OTHER: |
|---|---|

| HT(in) | WT( LBS) | TEMP | PULSE | RESP | BP |
|---|---|---|---|---|---|
| | | | | | |

My signature below indicates that based on review of the patient's medical history, immunization records, and physical examination performed and on file in my office, it is my impression that the student listed above, has received the required immunizations and that he/she meets the physical requirements for attendance at the Evelyn L. Spiro School of Nursing at Wagner College and is capable of participating, without restrictions, in clinical practice settings.

**PART B: QuantiFERON-TB Gold (blood test)**

DATE PERFORMED: _____ ☐NEGATIVE ☐POSITIVE ☐INDETERMINATE

**IF POSITIVE OR INDETERMINATE:**

REPEAT QuantiFERON DATE PERFORMED _____☐NEG ☐POS ☐IND

CHEST -XRAY DATE PERFORMED: _____☐NEG ☐POS

Treatment START DATE_____ ESTIMATED END DATE_____

**PART C: Urine Drug Screen**

DATE PERFORMED: _____ ☐NEGATIVE ☐POSITIVE

IF POSTIVE: INDICATE SUBSTANCE AND ACTION TAKEN_____

| PROVIDER NAME: | STAMP and SIGNATURE |
|---|---|
| PHONE NUMBER: | |