

WAGNER COLLEGE

Evelyn L. Spiro School of Nursing

PHYSICAL ASSESSMENT/QUANTIFERON/URINE DRUG SCREEN

REQUIRED ANNUALLY

ACADEMIC YEAR

2023-2024

DATE: _____

LAST NAME	FIRST NAME	Date of Birth	WAGNER ID
ADDRESS	CITY, STATE	ZIP	
GENDER IDENTITY <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	PHONE (cell)	Wagner email	

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

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

PART A: Complete History and Physical Examination

DATE OF EXAM	ALLERGIES: <input type="checkbox"/> NKDA LATEX <input type="checkbox"/> YES <input type="checkbox"/> NO OTHER:
--------------	--

HT(in)	WT(lb)	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, 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- 10

Must be performed through Clearing House see instructions _____

PROVIDER NAME:	STAMP and SIGNATURE
PHONE NUMBER:	