HEALTH REQUIREMENTS AND CLINICAL PRACTICE CLEARANCE

All graduate students entering clinical courses are required to have health records. The purpose of this health requirement and clinical practice clearance is to protect students as well as the patients with whom they will be working. It is also important to determine that the student is able to fulfill the objectives of the educational programs.

Clinical clearance also requires students to submit proof of completion of HIPAA Privacy Training, health insurance, and BCLS Certification. Graduate students are required to submit current NY State RN Registration and NY State RN License.

A list of required documents is illustrated in the table below:

| GRADUATE STUDENTS ENTERING CLINICAL COURSES ARE REQUIRED TO SUBMIT THE FOLLOWING DOCUMENTS: |
| 1. Annual history & physical examination & HCP Clearance (submit original HBSON's H&P Forms) |
| 2. Documentation of all listed immunizations, TB screening, and actual titer lab results for MMR, Varicella and Hepatitis B surface antibody |
| 3. Your personal health insurance card (submit copy) |
| 4. Certification by the American Heart Association Basic Cardiac Life Support (BCLS) for Health Care Workers/Providers (submit copy) |
| 5. Proof of HIPAA training |
| 6. A copy of your NY State RN License and current NY State RN Registration is required. |
| 7. Additional documentation may be required by affiliating agencies, such as drug screening & Criminal background checks. |

NOTE: Students are responsible for ensuring that all documentation remains up to date throughout each of their clinical placements.

Please upload all forms to: CASTLEBRANCH

Students are expected to have one copy of the health clearance forms available when on the clinical site ready for review if asked to produce the documents by the nursing leadership.

All required materials are to be submitted by:

April 20th for the Fall Semester
Nov. 20th for the Spring Semester

Students must upload forms that pertain to their health clearance prior to registering for clinical courses.

Always check that the version number located in the footer of this document matches the version published on the Hunter-Bellevue School of Nursing website. Failure to use the most current version of these health clearance forms may result in your submission being incomplete and regarded as late.

Download the latest version of these forms at www.hunter.cuny.edu/nursing/current-students/graduate-students/graduate-forms.
PERSONAL MEDICAL RECORD INFORMATION: To be filled out by Student

Student’s Name (PRINT) ____________________________________________
First ____________ Middle ____________ Maiden ____________

Address: _______________________________________________________

Cell Phone #: _______________________________ (Area Code – Number)

Date of Birth: ____________/__________/__________ Sex: (circle) M F

Parents Name If Dependent: _________________________________________

Emergency Contact Person: _________________________________________

Above Person’s Phone #: ________________________________

Above Person’s Relationship to you _________________________________

PERSONAL HEALTH HISTORY (completed by student)

Childhood Illnesses
Place a check in the column marked yes after each of the childhood illnesses you have had.

<table>
<thead>
<tr>
<th>Illnesses</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
<th>Others (fill in)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Chicken Pox</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Polio</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Rheumatic Fever</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Place a check in the column marked yes after all of the conditions/problems that you currently have or had in the past.

<table>
<thead>
<tr>
<th>Conditions/Problems</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
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<tr>
<td>Stroke</td>
<td></td>
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</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
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<tr>
<td>Joint Disease</td>
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</tr>
<tr>
<td>TB</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Emphysema</td>
<td></td>
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<tr>
<td>Asthma</td>
<td></td>
<td></td>
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<tr>
<td>Bronchitis</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Kidney Disease</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Venereal disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid disease</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Allergies</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Drug Sensitivities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach Problem</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulcers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulcers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nervous condition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Student to sign here: _____________________________________________

Date: ____________________________________________________________

Version # 7/17
HEALTH HISTORY
(Health Care Provider to Complete)

PAST MEDICAL HISTORY

_____________________________________________________

_____________________________________________________

_____________________________________________________

FAMILY HISTORY

_____________________________________________________

_____________________________________________________

_____________________________________________________

SOCIAL HISTORY

_____________________________________________________

_____________________________________________________

_____________________________________________________

Review of Systems:

General

Skin

Head

Eyes

Ears

Nose/Sinuses

Mouth/Throat

Neck

Breasts

Pulmonary

Cardiac

Gastrointestinal

Genitourinary

Musculoskeletal

Endocrine

Neuropsychiatric

Hematologic

Peripheral Vascular

Date: ______  Healthcare Provider Signature: ________________________________

Version # 7/17
PHYSICAL EXAM (Health Care Provider to Complete)

General:

Vital Signs: Ht: Wt: BP:

Skin

Head/ Hair

Eyes

Ears

Nose

Mouth/Throat

Neck/Shoulders

Back/Chest/Lungs

Breasts

Heart

Abdomen

Extremities/Joints

Peripheral Pulses

Genitalia

Rectum

Neurology

ASSESSMENT

PLAN

Healthcare Provider Signature: ____________________________

Date: __________
Healthcare Provider Documentation of Required Titers, Vaccines and Screening Tests

- To be completed and signed by healthcare provider.
- Revaccinations for negative titers are required.
- Attach actual titer laboratory reports & vaccination history for negative titers.
- Titers must be within the last 7 years. TITERS ARE REQUIRED ONLY ONCE.

<table>
<thead>
<tr>
<th>Titers</th>
<th>Date Drawn</th>
<th>Results: Please circle:</th>
<th>Revaccination Date/s If applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles (Rubeola) Titer</td>
<td></td>
<td>Positive, Negative, or Equivocal</td>
<td></td>
</tr>
<tr>
<td>Mumps Titer</td>
<td></td>
<td>Positive, Negative, or Equivocal</td>
<td></td>
</tr>
<tr>
<td>Rubella Titer</td>
<td></td>
<td>Positive, Negative, or Equivocal</td>
<td></td>
</tr>
<tr>
<td>Varicella Titer</td>
<td></td>
<td>Positive, Negative, or Equivocal</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B Surface Antibody Titer</td>
<td></td>
<td>Positive, Negative, or Equivocal</td>
<td>Dates of Vaccinations: #1 #2 #3 OR Signed Waiver</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vaccinations</th>
<th>Date Given</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria/ Tetanus Toxoid (TD) or TDaP administered within 10 years.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza *</td>
<td></td>
<td>No, signed waiver</td>
<td>Lot # Administered by:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Annual Screening</th>
<th>Date</th>
<th>Result Please circle;</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD or Quantiferon/Gold Blood Test Screening</td>
<td></td>
<td>Negative Positive</td>
<td>If positive, please attach chest X-ray report with physician clearance.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Negative Positive</td>
<td>Results Date: ____________________</td>
</tr>
</tbody>
</table>

Healthcare Provider Signature

______________________________________________
Date

Print Name

* Hunter- Bellevue School of Nursing requires documentation of:
1. Date influenza vaccine was given
2. Lot #
3. Health Care Provider or agency administering vaccine.
Student Health Clearance Form

Health Care Provider to Complete

Does the student have any disease or condition that would limit his or her full participation in the nursing program?

No ☐

By signing below, the health care provider has determined that the named individual is eligible for clinical practice and agrees with the following statement:
I find him/her to be in good physical and mental health; he/she is free from any health impairment that is of potential risk to patients, personnel, students, or faculty and which might interfere with the performance of his/her nursing student responsibilities, with or without a reasonable accommodation. If a reasonable accommodation is required, I have identified the accommodation and the basis of the accommodation on a separate attachment.

Health Care Provider (print name): ________________________________

New York State License #: _______________________________________

Signature: __________________________ Date: _____________________

Address: ___________________________________________________

Telephone #: ________________________________________________

Does the student have any disease or condition that would limit his or her full participation in the nursing program?

Yes ☐

If yes please describe:

________________________________________________________________________

________________________________________________________________________

Health Care Provider (print name): ________________________________

New York State License #: _______________________________________

Signature: __________________________ Date: _____________________
Hepatitis B Vaccine Waiver
(If vaccine waived, submit this form one time only)

I understand that during my clinical placement I may be exposed to blood or other potentially infectious materials, and I may be at risk of acquiring hepatitis B virus (HBV) infection, a serious disease.

Please check the appropriate statement:

_____ I decline hepatitis B vaccination at this time. I have been informed and understand the possible risks of acquiring hepatitis B.

_____ I am currently in the process of receiving the 3-dose series of hepatitis B vaccine at 0-, 1-, and 6-month intervals. I will obtain anti-HB serologic testing 1-2 months after dose #3. Until this process is completed, I have been informed and understand that I continue to be at risk of acquiring hepatitis B.

Print Student Name: ___________________________________________

Students Signature: ___________________________________________

Date: __________________

I have informed the above student of the risks associated with acquiring Hepatitis B.

Signature Healthcare Provider

Print name ___________________________ Date _______________________

Adapted from Occupational Safety & Health Administration
US. Department of Labor
Standard Number: 1910.1030 App A

Can be waived; If a student has waived the Hepatitis B vaccination, the healthcare provider’s signature indicates that the student has been advised by their healthcare provider of and understands the risks of not receiving the Hepatitis B vaccination.

Female students who believe they are pregnant must provide a letter from their health care provider indicating their expected delivery date and the lab result for Anti-Hepatitis B; although Hepatitis B vaccine is not contraindicated during pregnancy, the decision to receive their vaccination should be made in consultation with one’s health care provider.

Students are advised that some health care/clinical agencies will not allow anyone who has not received the Hepatitis B vaccination and/or demonstrated immunity to Hepatitis B to participate in a clinical rotation at their site.

Version # 7/17
Influenza Vaccine Waiver
(If vaccine waived, submit this form.)

Influenza is easily spread from person to person and those infected can be contagious before any signs of the flu are present. Young children, the elderly, and those with chronic health problems are at particular risk for complications from the flu.

I understand that if I do not receive the influenza vaccine, I am at greater risk of acquiring influenza and exposing patients, other healthcare providers, fellow students, faculty, and my family to influenza.

Please check both statements:

_____ I decline the influenza vaccination at this time. I have been informed and understand the possible risks of acquiring Influenza.

* _____ I will wear a mask when in the patient care areas at my clinical placement sites.

I understand that some health care/clinical agencies may not allow students who have not received the Influenza vaccination to participate in a clinical placement at their site.

Print Student Name: __________________________________________

Student Signature: ____________________________________________

Date: ______________

* Required by New York State Department of Health.
(New York State Department of Health Regulation: Section 2.59 of the New York State Sanitary Code, New York Codes Rules and Regulations (10 NYCRR). Effective as of the 2013-2014 influenza season.)
HUNTER COLLEGE CITY UNIVERSITY OF NEW YORK
HUNTER-BELLEVUE SCHOOL OF NURSING

HIPAA PRIVACY TRAINING
CERTIFICATION OF COMPLETION

Please view, “HIPAA: A Guide for Healthcare Workers” video at the Health Professions Education Center (HPEC), Hunter College Brookdale Campus (425 East 25th Street, West Mezzanine). After viewing the film, fill out the Certificate of Completion below and have it stamped by a member of the HPEC staff. The signed form is not valid without the HPEC stamp.

NOTE: If you have completed HIPAA training from another institution, you may submit documentation of that training.

CERTIFICATE OF COMPLETION

This is to certify that I have read the HIPAA Training Handbook and viewed “HIPAA: A Guide for Healthcare Workers”, video. I understand the confidentiality and privacy issues involved in client care and private health information sharing. As a health care profession, I am fully aware of my responsibilities involving patient confidentiality and privacy.

Name (Print): __________________________________________

Signature: __________________________________________

Date: ________________

HPEC Stamp __________________
HUNTER-BELLEVUE SCHOOL OF NURSING
CLINICAL PRACTICE CLEARANCE
and
STUDENT HANDBOOK ACKNOWLEDGEMENT

I _____________________________________ understand the agency to which I am assigned may require more health data than listed on the Hunter-Bellevue School of Nursing website.

I acknowledge that I have read the Hunter-Bellevue School of Nursing Student Handbook found on http://www.hunter.cuny.edu/nursing/repository/files/HBSON-Student-Handbook.pdf.

I hereby authorize Hunter-Bellevue School of Nursing to release my health clearance information and all associated documents, including: laboratory reports and immunization waivers, to any health care provider, who may require it in connection with my participation in a clinical course.

I also understand that it is my responsibility to update and keep current my H&P, PPD or Quantiferon, influenza vaccine, BCLS, NYS RN Registration, and health insurance.

I have kept three (3) copies for my own records if requested to present to the assigned official at the clinical site.

I agree that if I become ill, have surgical procedure and/or become hospitalized, develop a condition, or have an exacerbation of a condition that limits my ability to fulfill the HBSON Program requirements, I will obtain health clearance again from a health care provider before returning to the Program.

Student Signature: _______________________________ Date: ______________

Program: ____________________________________________
DOB: __________________________

HUNTER-BELLEVUE SCHOOL OF NURSING

GRADUATE STUDENT CHECK-OFF LIST OF
REQUIRED HEALTH AND CLINICL CLEARANCE DOCUMENTS

TO BE FILLED OUT BY HBSON STUDENT FOR THEIR RECORDS
DO NOT SUBMIT THIS FORM

1. Physical Examination Signed by HCP ______ Dated __________
2. Health Care Provider Health Clearance Form Signed ______ Dated __________
3. Lab documentation of required titers (MMR, VZ, Hep B surface antibody) complete:
   e. Hepatitis B surface antibody or signed Hep B waiver ______
4. Tetanus/TDaP (Type) ____________ (Date) ____________
5. Influenza ______ Date ____________ Adm’d by & Lot # info. ____________
or signed Influenza waiver ______
6. TB Screening Date ____________ (Circle) PPD / CXR / Quantiferon or T Spot
7. Name of Health Insurance (Copy of card attached) ______ Exp. Date: ____________
8. NYS RN License (Copy attached) ______
9. NYS RN Registration (Copy attached) Exp. Date: ____________
10. American Heart Association BCLS (Copy attached) Exp. Date: ____________
11. HIPAA Training: HPEC Stamped or proof from other institution ______ Date: ____________
12. Clinical Practice Clearance Agreement & Student Handbook Acknowledgment
   Signed ______ Dated ____________
13. Other __________________________________________