

Student last name (print) \_\_\_\_\_ First name (print) \_\_\_\_\_ Month and year of BIRTH DATE ( NUMBERS) \_\_\_\_\_  
EMAIL \_\_\_\_\_ ( circle)Fall, Spring, Summer 20\_\_\_\_ Program : \_\_\_\_\_

**HUNTER COLLEGE OF THE CITY UNIVERSITY OF NEW YORK  
HUNTER-BELLEVUE SCHOOL OF NURSING**

**HEALTH REQUIREMENTS AND CLINICAL PRACTICE CLEARANCE**

Establishment of a health record on all students entering the nursing program, Graduate and Undergraduate (Generic and RN Pathways), is required. The purpose of this health requirement and clinical practice clearance is to protect students as well as the clients 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.

All students are required to submit proof of health insurance, malpractice insurance, and BCLS Certification. RN Pathway and Graduate students are required to submit current registration information for NY State RN license.

**Please return all forms to:**

Undergraduate and Graduate Students go to the office of: Lula Mae Phillips / Donna Gill (Room 615W)

Both offices are at Hunter-Bellevue School of Nursing, 425 East 25<sup>th</sup> Street, New York, NY 10010-2590.

Students are to make 3 copies of all documents submitted, and are expected to have one copy available when on the clinical site ready for review if asked to produce the document by the nursing leadership.

All materials are to be submitted to the School of Nursing Prior to Registration in:

August for the Fall semester start or  
November for Spring semester start.

Students will not be permitted to begin courses with Clinical components if these materials are NOT filed.

Link for UG Health Form

<http://www.hunter.cuny.edu/nursing/repository/files/undergraduate-forms/Health%20Requirement%20Nursing%20UG-Final.pdf>

Student last name (print) \_\_\_\_\_ First name (print) \_\_\_\_\_ Month and year of BIRTH DATE ( NUMBERS) \_\_\_\_\_  
EMAIL \_\_\_\_\_ ( circle)Fall, Spring, Summer 20\_\_\_\_ Program : \_\_\_\_\_

### **Undergraduate and RN Pathway Students: Annual (Fall or Spring Semester)**

1. Physical Examination
2. All Lab tests listed Immunizations and **Titers Records**
3. Additional documentation required by affiliating agencies
4. Health Insurance
5. Malpractice Insurance \$1,000,000 / \$3,000,000 (minimum requirement)
6. Certification by the American Heart Association Basic Cardiac Life Support for Health Care Workers/Provider
7. **RN Pathway Students:** New York State RN License and current registration
8. Child abuse, and Infection control certification: Optional, dependant on specific facility.
9. HIPPA & Background Certification.

### **Graduate Students:Annual (Fall or Spring Semester)**

1. Physical Examination
2. All Lab tests listed Immunizations and **Titers Records**
3. Additional requirements required by affiliating agencies
4. Health Insurance
5. Malpractice Insurance \$1,000,000 / \$3,000,000 (minimum requirement)
6. **For all Nurse Practitioners students:**  
**Must have NURSE PRACTICIONER STUDENT Malpractice Insurance**
7. New York State RN License and current registration
8. American Heart Association Certification Basic Cardiac Life Support for Health Care Workers/Providers
9. Child abuse, and Infection control certification: Optional, dependant on specific facility.
10. HIPPA & Background Certification.

Student last name (print) \_\_\_\_\_ First name (print) \_\_\_\_\_ Month and year of BIRTH DATE ( NUMBERS) \_\_\_\_\_  
EMAIL \_\_\_\_\_ ( circle)Fall, Spring, Summer 20\_\_\_\_ Program : \_\_\_\_\_

When student has completed all health requirements give the student a copy of the statement below

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Present this document to your professor indicating that you have been cleared for Clinical placement

I \_\_\_\_\_ understand the agency to which I am assigned may require more health data than listed above.  
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, which may require it in connection with my participation in a clinical course. I also understand that it is my responsibility to update my H&P and PPD required by either the Undergraduate or Graduate Programs.  
I have kept three (3) copies for my own records **and 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.  
I have brought the original of the required completed/signed documents to: \_\_\_\_\_ RN from the Office of Recruitment, Retention and Progression (offices room 401 or 430A )

**Student Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Office of Recruitment, Retention and Progression** \_\_\_\_\_ **RN**



**HEALTH HISTORY AND PHYSICAL EXAM**  
**Health Care Provider to Complete**

**PAST MEDICAL HISTORY**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Review of Systems: Note any history of pathology in the following system**

General \_\_\_\_\_  
Skin \_\_\_\_\_  
Head \_\_\_\_\_  
Eyes \_\_\_\_\_  
Ears \_\_\_\_\_

Nose/Sinuses \_\_\_\_\_  
Mouth/Throat \_\_\_\_\_  
Neck \_\_\_\_\_  
Breasts \_\_\_\_\_

Pulmonary \_\_\_\_\_  
Cardiac \_\_\_\_\_  
Gastrointestinal \_\_\_\_\_  
Genitourinary \_\_\_\_\_

Musculoskeletal \_\_\_\_\_  
Endocrine \_\_\_\_\_  
Neuropsychiatric \_\_\_\_\_

Hematologic \_\_\_\_\_

Peripheral Vascular \_\_\_\_\_

**PHYSICAL EXAM Note any current problem detected**  
(Health Care Provider to Complete)

General: - \_\_\_\_\_

Vital Signs:- \_\_\_\_\_

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**

\_\_\_\_\_  
\_\_\_\_\_

**REQUIRED LABORATORY TEST**

To be completed by a Healthcare Provider  
Revaccinations for negative titers are required.  
Attach laboratory reports & Prior Vaccination History for Negative Titers

**1. Measles (Rubeola) Titer:**

Date Drawn \_\_\_\_\_ (Attach Laboratory test results)

Positive

Negative Revaccination Date: \_\_\_\_\_

(If Titer is Negative or Equivocal)

**2. Mumps Titer:** Date Drawn \_\_\_\_\_ (Attach Laboratory test results)

Positive

Negative Revaccination Date: \_\_\_\_\_

(If Titer is Negative or Equivocal)

**3. Rubella Titer:** Date Drawn \_\_\_\_\_ (Attach Laboratory test results)

Positive

Negative Revaccination Date: \_\_\_\_\_

(If Titer is Negative or Equivocal)

**4. Varicella Titer:** Date Drawn \_\_\_\_\_ (Attach Laboratory test results)

Positive

Negative Revaccination #1 Date: \_\_\_\_\_

(If Titer is Negative or Equivocal)

Revaccination #2 Date: \_\_\_\_\_

) "A Yb]b[ ]Hg`.

.....SSSS`MYgž8 UH` SSSSSSSSS

.....SSSS`BcžG][ b`K Ujj Yf"

\*. **Diphtheria/Tetanus Toxoid (Td or TdAP)** has been administered within ten (10) years?

Yes , Date \_\_\_\_\_

No. If no, Td AP administration is required. Date: \_\_\_\_\_

+. **PPD** \_\_\_date \_\_\_\_\_

Negative

Positive , if positive was x-ray done?, \_\_\_\_\_ results \_\_\_\_\_

, . **Hepatitis B: Titer:** Date Drawn \_\_\_\_\_ (Attach Laboratory test results)

Positive

Negative

**Dates of Vaccinations: # 1 \_\_\_\_\_ # 2 \_\_\_\_\_ # 3 \_\_\_\_\_ OR( next page)**



PROGRAM\_\_\_\_\_

FIRST NAME\_\_\_\_\_

LAST NAME\_\_\_\_\_

DOB\_\_\_\_\_

### **Meningitis Vaccine Waiver**

I understand that during my clinical learning experiences I may be exposed to potentially infectious materials, and I may be at risk of acquiring Meningitis infection, a serious disease. I have been given the opportunity to be vaccinated with the meningitis vaccine.

\_\_\_\_\_ I decline the meningitis vaccination at this time. I have been informed and understand the possible risks of acquiring meningitis.

**Date:** \_\_\_\_\_

**I have informed the above student of the risks associated with acquiring Meningitis.**

\_\_\_\_\_  
**Signature Health Care Provider (RN, NP, PA, MD, DO)**

\_\_\_\_\_  
**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 Meningitis 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 Meningitis vaccination.*

*Students are advised that some health care/clinical agencies will not allow anyone who has not received the Meningitis vaccination to participate in a clinical rotation at their site.*

**Signature of Health Care Provider** \_\_\_\_\_ **Date** \_\_\_\_\_

**Print or Type Name** \_\_\_\_\_

**Date** \_\_\_\_\_ **Tel. No:** \_\_\_\_\_

**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?

**Yes**  **No**

If yes please describe:

\_\_\_\_\_  
\_\_\_\_\_

Health Care Provider (Nurse Practitioner, Physician Assistant or Physician) 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 which 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. Habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances that may alter the individual's behavior has been considered in this evaluation. If a reasonable accommodation is required, I have identified the accommodation and the basis of the accommodation on a separate attachment.

NOTE: THIS FORM SHOULD NOT BE SIGNED UNLESS THE INDIVIDUAL IS ABLE TO PARTICIPATE FULLY IN ACTIVITIES REQUIRED BY HIS OR HER NURSING PROGRAM.

\_\_\_\_\_

**Health Care Provider (PRINT Name)** \_\_\_\_\_

**New York State License #** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address** \_\_\_\_\_

**Telephone #:** \_\_\_\_\_

**Email: -** \_\_\_\_\_

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**HUNTER COLLEGE OF THE CITY UNIVERSITY OF NEW YORK  
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**CERTIFICATE OF COMPLETION**

**This is to certify that I:**

**NAME:** \_\_\_\_\_

**Have read the HIPPA Training Handbook and that I have viewed the Video, “Keep It To Yourself”. I understand the confidentiality and privacy issues involved in client care and personal client health data information sharing. As a health care professional, I am fully aware of my responsibility involving patient confidentiality and privacy.**

**Name (Print)** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

TO: Nursing Students

FROM: Kathleen M. Nokes, PhD, RN, FAAN  
Director, Graduate Program

DATE: September 25, 2007

RE: Criminal Background Checks in Connection with Clinical Placements

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As you know, nursing students are required to complete clinical experiences at certain health care facilities as part of their degree program at The City University of New York. CUNY has been informed that some of these facilities will now require criminal background checks of students who participate in such clinical experiences and may refuse to accept certain students based on the results of these background checks.

We will keep you informed of any requirements that may affect CUNY nursing students for the semester beginning Spring Semester 2005. Meanwhile, please sign the statement below to confirm your receipt of this notice. Thank you.

**Student's Statement**

I am aware that I may have to obtain a criminal background check to comply with the rules of a health care facility to which I will be sent for an on-site clinical experience as part of the requirements of my nursing program. I understand that, depending on the results of such a criminal background check, I may not be able to complete the degree requirements for the nursing program and may have to withdraw from the program.

Student's Name: \_\_\_\_\_

Student's Signature: \_\_\_\_\_

College: \_\_\_\_\_

Date: \_\_\_\_\_