Student last name (print) _____ First name (print) _____
Month and year of birth date (numbers) _____ Student ID # _____
Hunter email: _____@myhunter.cuny.edu (circle) fall, spring, summer 20 _____

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

HEALTH REQUIREMENTS AND CLINICAL PRACTICE CLEARANCE

All undergraduate 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. Undergraduate students in the RN to BS Program 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:

UNDERGRADUATE 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. For RN-BS Program: a copy of your current New York State RN Registration & License is required.
7. Additional documentation may be required by affiliating agencies, such as drug screening.

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 (see p. 2)

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 documents by the nursing leadership.

All required materials are to be submitted by:

July 15th

Students will not be permitted to begin their clinical practicum if these materials are not submitted.

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/undergraduate-students/undergraduate-program

Student last name (print) _____ First name (print) _____
Month and year of birth date (numbers) _____ Student ID # _____
Hunter email: _____@myhunter.cuny.edu (circle) fall, spring, summer 20 _____

Managing Clinical Compliance Requirements in CastleBranch

The School of Nursing has partnered with CastleBranch, one of the top ten background check and compliance management companies in the nation to provide you a secure account to manage your time sensitive school and clinical requirements. After you complete the order process and create your account, you can log in to your account to monitor your order status, view your results, respond to alerts, and complete your requirements.

You will return to your account by logging into www.castlebranch.com and entering your username (email used during order placement) and your secure password.

To place your order, go to:

https://portal.castlebranch.com/UV15

When placing your initial order, you will be prompted to create a secure *myCB* account. From within *myCB*, you will be able to:

- ✓ **View order results**
- ✓ **Manage requirements**
- ✓ **Complete tasks**
- ✓ **Upload documents**
- ✓ **Place additional orders**

Please have ready personal identifying information needed for security purposes.

The email address you provide will become your username.

Need Help?

Visit https://mycb.castlebranch.com/help for more information.

Contact Us: 888.914.7279 or servicedesk.cu@castlebranch.com

Version # 8/17

Student last name (print) _____ First name (print) _____
Month and year of birth date (numbers) _____ Student ID # _____
Hunter email: _____@myhunter.cuny.edu (circle) fall, spring, summer 20 _____

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
Month/ Day/Year

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.

	Yes		Yes		Yes
Measles		Rubella		Chicken Pox	
Mumps		Polio		Rheumatic Fever	

Others (fill in) _____ _____ _____

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

	Yes		Yes		Yes
Cardiac disease		Hypertension		Stroke	
Diabetes		Joint Disease		TB	
Emphysema		Asthma		Bronchitis	
Cancer		Kidney Disease		Venereal disease	
Eye Problems		Hearing Problems		Thyroid disease	
Anemia		Allergies		Drug Sensitivities	
Stomach Problem		Ulcers		Bowel disease	
Hospitalizations		Headaches		Nervous condition	

Student to sign here: _____

Date: _____

Student last name (print) _____ First name (print) _____
Month and year of birth date (numbers) _____ Student ID # _____
Hunter email: _____@myhunter.cuny.edu (circle) fall, spring, summer 20 _____

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 # 8/17

Student last name (print) _____ First name (print) _____
Month and year of birth date (numbers) _____ Student ID # _____
Hunter email: _____@myhunter.cuny.edu (circle) fall, spring, summer 20 _____

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:_____

Version # 8/17

Student last name (print) _____ First name (print) _____
Month and year of birth date (numbers) _____ Student ID # _____
Hunter email: _____@myhunter.cuny.edu (circle) fall, spring, summer 20 _____

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 & vaccine history for negative titers.**
- **Titers must be within the last 7 years. TITERS ARE REQUIRED ONLY ONCE.**

Titers	Date Drawn	Results: Please circle:	Revaccination Date/s If applicable
Measles (Rubeola) Titer		Positive, Negative, or Equivocal	
Mumps Titer		Positive, Negative, or Equivocal	
Rubella Titer		Positive, Negative, or Equivocal	
Varicella Titer		Positive, Negative, or Equivocal	
Hepatitis B Surface Antibody Titer		Positive, Negative, or Equivocal	Dates of Vaccinations: #1_____ #2 ____ #3____ OR Signed Waiver_____
Vaccinations	**Date Given**		
Diphtheria/ Tetanus Toxoid (TD) or TDaP administered within 10 years.			
Meningitis		No, signed waiver _____	
Influenza *			Lot # Administered by:
Annual Screening	**Date**	**Result Please circle;**	**Follow-Up**
PPD or Quantiferon/Gold Blood Test Screening		Negative Positive Negative Positive	If positive, please attach chest X-ray report with physician clearance. Results Date: _____

_____
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.

Version # 8/17

Student last name (print) _____ First name (print) _____
Month and year of birth date (numbers) _____ Student ID # _____
Hunter email: _____@myhunter.cuny.edu (circle) fall, spring, summer 20 _____

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:** _____

Student last name (print) _____ First name (print) _____
Month and year of birth date (numbers) _____ Student ID # _____
Hunter email: _____@myhunter.cuny.edu (circle) fall, spring, summer 20 _____

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.

Student last name (print) _____ First name (print) _____
Month and year of birth date (numbers) _____ Student ID # _____
Hunter email: _____@myhunter.cuny.edu (circle) fall, spring, summer 20 _____

Meningitis Vaccine Waiver

ONLY FILL OUT & SUBMIT IF YOU DID NOT RECEIVE A MENINGITIS VACCINE

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.

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

_____
Print Student Name

_____
Student's Signature

Date: _____

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

_____
Signature of Healthcare Provider

_____ _____
Print name **Date**

Telephone No. _____

Student last name (print) _____ First name (print) _____
Month and year of birth date (numbers) _____ Student ID # _____
Hunter email: _____@myhunter.cuny.edu (circle) fall, spring, summer 20 _____

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 current or future health care profession, I am fully aware of my responsibilities involving patient confidentiality and privacy.

Name (Print) _____

Signature: _____

Date: _____

HPEC Stamp _____

Student last name (print) _____ First name (print) _____
Month and year of birth date (numbers) _____ Student ID # _____
Hunter email: _____@myhunter.cuny.edu (circle) fall, spring, summer 20 _____

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

I _____understand the agency to which I am
STUDENT'S NAME
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 (for RN-BS students), 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 & Year: _____

Student last name (print) _____ First name (print) _____
Month and year of birth date (numbers) _____ Student ID # _____
Hunter email: _____@myhunter.cuny.edu (circle) fall, spring, summer 20 _____

Hunter-Bellevue School of Nursing
Check List of Required Documents - Cover Sheet

To Be Filled Out by HBSON Undergraduate Student FOR THEIR RECORDS

DO NOT SUBMIT

Note: INCOMPLETE FORMS WILL NOT BE ACCEPTED

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:

   a. Measles _____ b. Mumps _____ c. Rubella _____ d. Varicella _____

   e. Hepatitis B surface antibody or signed Hep B waiver _____

4. Tetanus/TDaP (Type) _____ (Date) _____

5. Meningitis _____ Date _____ or signed Meningitis waiver _____

6. Influenza _____ Date _____ Adm'd by & Lot # info. _____

7. TB Screening Date _____ (Circle) PPD / CXR / Quantiferon or T Spot

8. Name of Health Insurance (Copy of card attached) _____ Exp. Date: _____

9. **FOR RN-BS STUDENTS:**

   NYS RN License (Copy attached) _____

   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 Acknowledgement
    Signed_____ Dated _____

13. Other _____