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:

<table>
<thead>
<tr>
<th>UNDERGRADUATE STUDENTS ENTERING CLINICAL COURSES ARE REQUIRED TO SUBMIT THE FOLLOWING DOCUMENTS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Annual history &amp; physical examination &amp; HCP Clearance (submit original HBSON’s H&amp;P Forms)</td>
</tr>
<tr>
<td>2. Documentation of all listed immunizations, TB screening, and actual titer lab results for MMR, Varicella and Hepatitis B surface antibody</td>
</tr>
<tr>
<td>3. Your personal health insurance card (submit copy)</td>
</tr>
<tr>
<td>4. Certification by the American Heart Association Basic Cardiac Life Support (BCLS) for Health Care Workers/Providers (submit copy)</td>
</tr>
<tr>
<td>5. Proof of HIPAA training</td>
</tr>
<tr>
<td>6. For RN-BS Program: a copy of your current New York State RN Registration &amp; License is required.</td>
</tr>
<tr>
<td>7. Additional documentation may be required by affiliating agencies, such as drug screening.</td>
</tr>
</tbody>
</table>

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

Version # 8/17
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?
Contact Us: 888.914.7279 or servicedesk.cu@castlebranch.com
PERSONAL MEDICAL RECORD INFORMATION: To be filled out by Student

Student’s Name (PRINT) ___________________________________________ First name (print) ___________________________________________

Address: _______________________________________________________

Cell Phone #: ___________________________________________________

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.

<table>
<thead>
<tr>
<th>Illness</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>
</tr>
<tr>
<td>Chicken Pox</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatic Fever</td>
<td></td>
<td></td>
<td></td>
<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>Condition</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
<td>Stroke</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td>TB</td>
</tr>
<tr>
<td>Joint Disease</td>
<td></td>
<td></td>
<td>TB</td>
</tr>
<tr>
<td>Emphysema</td>
<td></td>
<td></td>
<td>Bronchitis</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td>Venereal disease</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td></td>
<td></td>
<td>Venereal disease</td>
</tr>
<tr>
<td>Eye Problems</td>
<td></td>
<td></td>
<td>Thyroid disease</td>
</tr>
<tr>
<td>Hearing Problems</td>
<td></td>
<td></td>
<td>Thyroid disease</td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
<td>Allergies</td>
</tr>
<tr>
<td>Stomach Problem</td>
<td></td>
<td></td>
<td>Drug Sensitivities</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
<td>Bowel disease</td>
</tr>
<tr>
<td>Ulcers</td>
<td></td>
<td></td>
<td>Bowel disease</td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
<td>Bowel disease</td>
</tr>
</tbody>
</table>

Student to sign here: _____________________________________________

Date: __________________________

Version # 8/17
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 # 8/17
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: ______________________

Version # 8/17
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.

<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>

Vaccinations

<table>
<thead>
<tr>
<th>Vaccinations</th>
<th>Date Given</th>
<th></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>
<td></td>
</tr>
<tr>
<td>Meningitis</td>
<td></td>
<td>No, signed waiver</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza *</td>
<td></td>
<td></td>
<td></td>
<td>Lot # Administered by:</td>
</tr>
</tbody>
</table>

Annual Screening

<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>or quantiferon/gold blood test screening</td>
<td></td>
<td>Negative Positive</td>
<td>Results</td>
</tr>
</tbody>
</table>

Healthcare Provider Signature ____________________________ Date __________

Print Name ____________________________ Date __________

* 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 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.
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. _____________________
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 ____________________
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-

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: ________________________________

Version # 8/17
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 ________________________________

Version # 8/17