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 up-to-date 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 (found at HPEC website: www.hunter.cuny.edu/shp/centers/hpec), health insurance, BLS Certification (American Heart Association only – NO Red Cross), and the National Student Nurses Association (NSNA) membership. Undergraduate students in the RN to BS Program are required to submit current NY State RN Registration and NY State RN License.

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 and screenings including, but not limited to: influenza, COVID-19, TB screening (quantiferon testing NOT PPD), and actual titer lab results for MMR, Varicella, Hepatitis B surface antibody, Hepatitis C 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) – you CANNOT obtain American Red Cross certification.
5. Proof of HIPAA training (see HPEC website above).
6. For RN-BS Program: a copy of your current New York State RN Registration & License is required.
7. Annual drug screening (it MUST be a 10 panel test).

NOTE: Students are responsible for ensuring that all documentation remains up to date throughout each of their clinical placements. If any portion is incomplete or expired, students will not receive clinical clearance points in their course grade. If requirements are met after the due date, or expiration, points will NOT be returned.

Please upload all forms to: CASTLEBRANCH (see p. 2)

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

All required materials are to be submitted by:

New INCOMING STUDENTS: A2D AUGUST 3rd. Generic students, NOV. 2nd.
ALL returning students Fall semester: AUGUST 3rd
ALL returning students Spring semester: JAN 2nd

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

DOCUMENT VERSION NUMBERING: Always check that the version number located in the footer of this document matches the version published on the Hunter College School of Nursing website. Failure to use the most current forms may result in your submission being regarded as incomplete or late. Download the latest version at www.hunter.cuny.edu/nursing/current-students/undergraduate-students/undergraduate-program

Version # 6/21/21
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 LEGAL NAME (PRINT) ____________________________________________
First       Middle       Last

Address: ________________________________________________________________

Cell Phone #: ____________________________ (Area Code – Number)

Date of Birth: ____________________________ Sex: (circle) M  F  Decline
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>
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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>
<td></td>
<td></td>
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<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>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></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint Disease</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>TB</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emphysema</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bronchitis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venereal disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug Sensitivities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach Problem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulcers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nervous condition</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Student to sign here: ______________________________________________________

Date: ____________________________

Version # 6/21/21
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 # 6/21/21
PHYSICAL EXAM (Health Care Provider to Complete)

General: ____________________________________________________________


Skin: ______________________________________________________________

Head/ Hair: _________________________________________________________

Eyes: ______________________________________________________________

Ears: ______________________________________________________________

Nose: ______________________________________________________________

Mouth/Throat: _______________________________________________________

Neck/Shoulders: ____________________________________________________

Back/Chest/Lungs: __________________________________________________

Breasts: ____________________________________________________________

Heart: ______________________________________________________________

Abdomen: __________________________________________________________

Extremities/Joints: __________________________________________________

Peripheral Pulses: __________________________________________________

Genitalia: __________________________________________________________

Rectum: ____________________________________________________________

Neuro: __________________________________________________________________________________________

ASSESSMENT
________________________________________________________________________
________________________________________________________________________

BASELINE TB RISK ASSESSMENT (Completed once):

1. Temporary or permanent residence of ≥1 month in a country with a high TB rate. (Any country other than the United States, Canada, Australia, New Zealand, and those in Northern Europe or Western Europe). Y / N
2. Current or planned immunosuppression, including human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication. Y / N

3. Close contact with someone who has had infectious TB disease since the last TB test. Y / N

ANNUAL TB SCREENING QUESTIONS:

Within the past year have you experienced?

- A cough lasting longer than 3 weeks Y / N
- Coughing up blood/sputum/phlegm from deep inside the lungs Y / N
- Unexplained weight loss Y / N
- Night sweats Y / N
- Fever Y / N
- Weakness/fatigue Y / N
- Loss of appetite? Y / N

PLAN

________________________________________________________________________________________

________________________________________________________________________________________

Healthcare Provider Signature (MD/NP) ______________________________________________________

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 & 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:</th>
<th>Revaccination Date/s</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_____</td>
</tr>
<tr>
<td>Hepatitis C antibody</td>
<td></td>
<td>Positive, Negative, or Equivocal</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vaccinations</th>
<th>Date Given</th>
<th>Lot info</th>
<th>Lot info</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>Meningitis</td>
<td></td>
<td>Lot #:</td>
<td>No, signed waiver</td>
</tr>
<tr>
<td>Influenza (annual requirement) *</td>
<td></td>
<td>LOT #</td>
<td>Administered by: Site:</td>
</tr>
<tr>
<td>COVID-19 (Subject to changing guidelines)</td>
<td>Dose 1:</td>
<td>LOT #</td>
<td>Dose 2 (if applicable): LOT #</td>
</tr>
<tr>
<td></td>
<td>LOT #</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TB &amp; Drug Screening</th>
<th>Date</th>
<th>Result</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantiferon/Gold Blood Test Screening (one-time test, not annual) (Please do NOT</td>
<td>Negative</td>
<td>If positive, please attach chest X-ray report with physician clearance. Results: Date:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Positive</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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obtain a PPD)

<table>
<thead>
<tr>
<th>Annual 10 panel Drug Screening</th>
<th>Negative</th>
<th>Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></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 ☐ Yes ☐

If “Yes” please explain: ________________________________

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 #: ________________________________

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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. _______________________

Version # 6/21/21
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 (*if completed remotely, follow provided directions for submission).

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 professional, I am fully aware of my responsibilities involving patient confidentiality and privacy.

Name (Print) __________________________________________

Signature: __________________________________________

Date: ______________________________________________

HPEC Stamp (if applicable) __________________________
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, Quantiferon, influenza vaccine, BLS, NYS RN Registration (for RN-BS students), NSNA membership, 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 a 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: _____________________________
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:
   e. Hepatitis B surface antibody _____  f. Hepatitis C antibody testing ______
4. Tetanus/TDaP (Type) __________________  (Date) __________
5. Meningitis _____   Date ___________ or signed Meningitis waiver ______
6. Influenza _____  Date ___________   Adm’d by & Lot # info. _______________
7. COVID-19 vaccination _____ Date ________ Lot# __________
8. TB Screening Date ________  Quantiferon / CXR
9. Name of Health Insurance (Copy of card attached) ______ Exp. Date: __________
10. FOR RN-BS STUDENTS:
    NYS RN License (Copy attached) ______
    NYS RN Registration (Copy attached)  Exp. Date: __________
11. American Heart Association BLS (Copy attached)        Exp. Date: __________
12. HIPAA Training: HPEC Stamped or proof from other institution _____  Date: __________
13. Clinical Practice Clearance Agreement & Student Handbook Acknowledgement
    Signed______ Dated __________
14. NSNA membership __________
15. Annual drug testing (it MUST be a 10-panel test, uploaded to Castlebranch) __________
16. Other (if applicable) ____________________________

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