ALL 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

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 # 7/17
# 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.

<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>disease</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>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emphysema</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bronchitis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</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>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
<td></td>
<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>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: ______________

Version # 7/17
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___</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>OR Signed Waiver</td>
</tr>
</tbody>
</table>

**Vaccinations**

<table>
<thead>
<tr>
<th>Vaccinations</th>
<th>Date Given</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria/ Tetanus Toxoid (TD) or TDaP administered within 10 years.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningitis</td>
<td></td>
<td>No, signed waiver</td>
</tr>
<tr>
<td>Influenza *</td>
<td>Lot #</td>
<td>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</td>
<td></td>
<td>Negative</td>
<td>If positive, please attach chest X-ray report with physician clearance.</td>
</tr>
<tr>
<td>Quantiferon/Gold Blood Test Screening</td>
<td></td>
<td>Positive</td>
<td>Results Date: ___________</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.
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: _________________________

Version # 7/17
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 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: ___________________________
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 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 ____________________________________________