Student Last Name (print) _____ First Name (print) _____
Month and Year of birth date (numbers) __MM__ /__YYYY__ Student ID # _____
Hunter email: _____@myhunter.cuny.edu (circle) ◯fall, ◯spring, ◯summer 20_____

Clear

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, 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
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

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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

Two packages are available: Undergraduate and Graduate

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

Student Last Name (print) _____ First Name (print) _____
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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.

	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) __MM__ /__YYYY__ 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**_____

Student Last Name (print) _____ First Name (print) _____
Month and Year of birth date (numbers) __MM__ /__YYYY__ 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: _____ HR: _____

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, Y / N

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.

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:_____

Student Last Name (print) _____ First Name (print) _____
Month and Year of birth date (numbers) __MM__ /__YYYY__ Student ID # _____
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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_____**
Hepatitis C antibody		**Positive, Negative, or Equivocal**	
Vaccinations	**Date Given**	**Lot info**	**Lot info**
Diphtheria/ Tetanus Toxoid (TD) or TDaP **Administered within 10 years.**			
Meningitis		**Lot #:**	**No, signed waiver _____**
Influenza (annual requirement) *			**LOT # Administered by: Site:**
COVID-19 **(Subject to changing guidelines)**		**Dose 1: LOT #**	**Dose 2 (if applicable): LOT #**
TB & Drug Screening	**Date**	**Result Please circle;**	**Follow-Up**
Quantiferon/Gold Blood Test Screening (one-time test, not annual)		**Negative Positive**	**If positive, please attach chest X-ray report with physician clearance. Results:**

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(Please do NOT obtain a PPD)			**Date:** _____
Annual 10 panel Drug Screening		**Negative** **Positive**	

_____
Healthcare Provider Signature

_____**Date**_____
Print Name

***The Hunter College School of Nursing requires documentation of:**
1) the date the influenza vaccine was given
2) the Lot #
3) the 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 #: _____

Student Last Name (print) _____ First Name (print) _____
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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. _____

Student Last Name (print) _____ First Name (print) _____
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HUNTER COLLEGE CITY UNIVERSITY OF NEW YORK
HUNTER-BELLEVUE SCHOOL OF NURSING

HIPAA PRIVACY TRAINING CERTIFICATION OF COMPLETION

HIPAA | NCLEX Review
https://youtu.be/Lh1TISuYI6E

New Nurse Tips – HIPAA Patient Privacy Issues in Nursing
https://youtu.be/7LRrFMHOWws

Please review the videos above and complete the attestation below AND upload this form to Castlebranch.

I _____ reviewed both required HIPAA videos.
STUDENT'S NAME

Student Signature _____ **Date** _____

Program & Year: _____

Student Last Name (print) _____ First Name (print) _____
Month and Year of birth date (numbers) __MM__ /__YYYY__ Student ID # _____
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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, 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: _____

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Hunter-Bellevue School of Nursing
Check List of Required Documents

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 _____ 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 certificate 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) _____