LEHMAN COLLEGE DEPARTMENT OF NURSING
ANNUAL HEALTH CLEARANCE REQUIREMENTS

READ ME FIRST

Each Department of Nursing student must have current health clearance prior to each clinical nursing course:

Undergraduate (Generic/Accelerated, RN-BS) clinical courses:  (NUR 301, 303, 304, 400, 405, 409).

Graduate (Master’s/Post-Master’s Certificate) clinical courses:  (NUR 700, 732, 733, 738, 739, 749.1, 749.2, 749.3, 751, 752, 770, 771, 772, 773, 774, 775, 776).

Health clearance is required by the New York State Department of Health to determine that health care workers and students do not pose a health risk to clients, families or co-workers and to assure that the student is physically able to fulfill the objectives of the educational program.

Attached is an examination form and list of laboratory tests which must be completed and signed by a licensed healthcare provider (physician, physician’s assistant, or nurse practitioner) of your choice.  The completed form, including the evaluation of lab results, must be returned to the Department of Nursing.

Documentation of immunization/immunity to communicable disease needs to be completed only once if immunity is confirmed.

IMPORTANT NOTE:  Some clinical sites may require a drug test and/or background check.  This is not required by Lehman College or the Nursing Department, but if required by the clinical site to comply with its rules and procedures, nursing students will be responsible for the costs involved.  Lehman College and the Nursing Department will not pay for or reimburse for this expense.

Health Clearance is valid for 12 (twelve) months

INSTRUCTIONS

Student:  Fill in the upper top portion of each page of this document, complete pages 3, 7, and 8, and sign where required.  Your healthcare provider must complete and sign pages 4, 5, 6, and 7.  Fill in your name and/or signature where required.

Submit this original Health Clearance Form and any Lab Reports. Also attach one copy each of your signed CPR card (both sides), and Liability Certificate of Insurance (RN-BS, Master’s/Post-Master’s students only) at the same time to the Nursing Department by the following deadlines:

* New Generic/Accelerated students:  Submit on or before the day of scheduled Nursing Orientation.

* Current Generic/Accelerated and RN-BS students:  Submit eight weeks before the official first day of semester in which you have a clinical course.  RN-BS students: also submit a copy of NYS Registered Nurse License and Registration.

* Current Master’s/Post-Master’s students:  Submit by deadlines below to facilitate early field placements.  Also submit a copy of your NYS Registered Nurse License and Registration.

  A.  Fall Request –Deadline June 15th
  B.  Spring Request –Deadline October 15th
  C.  Summer Request –Deadline March 15th

 FAILRE TO RETURN YOUR COMPLETED, ORIGINAL HEALTH CLEARANCE FORM WITH ALL REQUIRED DATA, AND A COPY OF YOUR INSURANCE CERTIFICATE AND CPR CARD BY THE DEADLINE WILL RESULT IN YOU BEING BARRED FROM CLINICAL WHICH WILL LEAD TO AN AUTOMATIC FAILURE

MAKE EXTRA COPIES OF YOUR COMPLETED HEALTH CLEARANCE FORM, LIABILITY INSURANCE CERTIFICATE, AND CPR CARD FOR YOUR PERSONAL RECORDS.  THE NURSING DEPARTMENT WILL NOT BE MAKE COPIES FOR YOU.

ONCE SUBMITTED, HEALTH CLEARANCE WILL NOT BE RELEASED TO YOU TO MAKE COPIES OR TO BORROW FOR USE AT MEDICAL APPOINTMENTS/SCREENINGS.

ALWAYS CARRY A SET OF THESE DOCUMENTS WITH YOU TO YOUR CLINICAL SITE.

RENEW AND SUBMIT YOUR HEALTH CLEARANCE, LIABILITY INSURANCE (RN-BS, Master’s/Post-Master’s Students only), AND CPR TO THE NURSING DEPARTMENT BEFORE THEY EXPIRE.

RETURN COMPLETED FORMS TO:  Department of Nursing, Building T-3, Room 201

CONTINUE READING NEXT PAGE
READ ME NEXT

DOCUMENT REQUIREMENTS FOR CLINICAL PLACEMENT AND PERFORMANCE
Generic/Generic-Accelerated, RN-BS, Master’s/Post-Master’s Certificate

IMPORTANT NOTE: Some clinical sites may require a drug test and/or background check.

- Submit original or copy of document as specified below in person to the Nursing Department, Bldg. T-3, Rm 201. Nursing is not responsible for delayed/lost documents sent by mail. Check off the completion of your requirements below.
- Make a few copies of these documents for your own or personal medical use. Nursing will not make copies for you. Nursing is not responsible for delayed/lost documents sent by mail. Check off the completion of your requirements below.
- Carry a set of these documents with you to the clinical site to have available if requested for review/submission by the clinical site manager/coordinator, preceptor, or your clinical or lecture instructor.

| A. | Department of Nursing’s Health Clearance Form - Valid for 12 months from date of exam | Check-Off Completed |

**SUMMARY OF REQUIRED HEALTH CLEARANCE**

1. **Physical Examination annually.**

2. **Laboratory Tests** – Evaluation of test results as “Normal” or “Abnormal” must be done by the licensed Healthcare Provider.
   - CBC with Differential
   - Urinalysis with Microscopic exam
   - Hepatitis B Antigen/Antibody Titre
   - Rubella Titre – Positive titre required (give exact numbers). Immunization required if titres are not immune.
   - Varicella (Chicken Pox) – Positive titre required.
   - Measles, Mumps (if no documentation of immunizations available)

3. **Immunizations**
   - Tetanus-Diphtheria – Within 10 years (give exact date)
   - PPD – All students must have a PPD, including those who have previously received BCG. A chest x-ray is required at the time of conversion and every 5 years thereafter (or less if required by the clinical site).
     - A copy of the radiology report must be attached to the Health Clearance Form.
     - Students who convert to PPD positive must provide evidence that they are being treated prophylactically, as per New York State and CDC guidelines, in order to continue in clinical.
   - Students who are PPD negative must have a repeat PPD prior to each clinical semester.
   - Mumps – Documentation of immunization or positive titre required.
   - Measles – Documentation of immunization or positive titre required.
   - **Vaccines**
     - Influenza Vaccine. If you decline this vaccine, then you must submit a letter from your healthcare provider that verifies the condition that prevents you from receiving this vaccine. Both you and your doctor must sign page 7.
     - Hepatitis B Vaccine. If you decline this vaccine, then you must sign the Declination of Hepatitis B Vaccine (p 8).

4. **Additional requirements may be imposed** by specific agencies with which the Department of Nursing affiliates.
   These include, but are not limited to:
   - Drug and alcohol screening
   - Background investigation including criminal record name search
   - Child Abuse and Maltreatment inquiry.

B. **Cardio-Pulmonary Resuscitation (CPR)** (also known as Basic Cardiac Life Support (BLS/BCLS) for Healthcare Providers - Source: The American Heart Association CPR classroom training – valid for 2 years - ALL NURSING STUDENTS)
- Submit 1 copy of each side of your signed CPR card.

C. **Malpractice Liability Insurance** - valid for 12 months – ALL RN-BS AND NURSING STUDENTS
- Submit 1 copy of your Certificate of Insurance

D. **Consent to Release Documents form** - Submit signed original - ALL RN-BS, MASTER’S/POST-MASTER’S STUDENTS

E. **RN License and Registration** – ALL RN-BS, MASTER’S/POST-MASTER’S STUDENTS ONLY
- Submit a copy of your current New York State RN license and registration.

F. **Application for Clinical Placement** – ALL MASTER’S/POST-MASTER’S STUDENTS ONLY
- See Graduate Documents & Forms at http://www.lehman.cuny.edu/academics/nursing/graduate-forms.php
LEHMAN COLLEGE DEPARTMENT OF NURSING

ANNUAL HEALTH CLEARANCE RECORD
(Expires 12 (twelve) months from date of your physical exam)

Name______________________________
Print First ________________________ Middle _________ Last ______________________
Sex _______ Age ________

Street Address____________________________________________________________________________

City_______________________ State_____ Zip__________ Phone #__________________

Lehman Email _____________________________________________________________________

Personal Health History: (To be completed by the student)

Have you ever had any of the following? (Circle YES and indicate date, or circle NO)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back trouble</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin Problems.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulcers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Heart Murmur</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Cardiac Disease</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Describe any items checked YES above: ___________________________________________________________

_________________________________________________________________________________________

List previous serious illnesses/operations/hospitalizations: __________________________________________

_________________________________________________________________________________________

I understand that some clinical sites may require a drug test and/or background check that I may be required to obtain and pay for in order to comply and participate. If the site denies my placement based on the results and the Nursing Department is unable to place me at another site, then I may not be able to complete the clinical practicum requirements and will have to withdraw from the nursing program.

Student’s Signature: ___________________________ Today’s Date: ________________
LEHMAN COLLEGE DEPARTMENT OF NURSING

Annual Physical Examination: (To be completed by a licensed Healthcare Provider)

Student's Name: ___________________________________________ Today's Date: __________

Height:______  Weight:______  B.P:______mmHg  Pulse:______  Temp:______

Visual Acuity: O.D.______  Corrected:______  O.S.______  Corrected:______

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>Normal</th>
<th>Abnormal</th>
<th>REMARKS (Describe Abnormalities)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nose &amp; Sinuses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mouth &amp; Throat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gums &amp; Teeth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Ears, Hearing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thorax &amp; Lungs</td>
<td></td>
<td></td>
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<tr>
<td>Breast</td>
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<td></td>
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<tr>
<td>Heart &amp; Vascular</td>
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<tr>
<td>Lymphatics</td>
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<tr>
<td>Abdomen</td>
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<td></td>
<td></td>
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<tr>
<td>Hernia</td>
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<td></td>
<td></td>
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<tr>
<td>Anus &amp; Rectum</td>
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<td></td>
<td></td>
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<tr>
<td>Genito-Urinary</td>
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<td></td>
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<tr>
<td>Endocrine</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal/Spine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hematologic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental/Emotional</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is there any emotional, mental or physical condition for which this student is under medical supervision and/or taking medication?   Yes_____   No_____

Specify: __________________________________________________________________________________________

______________________________________________________________________________________________

Healthcare Provider Name: ___________________________ License # __________ State: __________

Signature: ___________________________________________ Exam Date: __________

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LEHMAN COLLEGE DEPARTMENT OF NURSING

Laboratory Test Results:

Urinalysis: ____________  CBC: ____________

PPD*: Negative ____________  Positive ____________  Chest x-ray*: ____________

Date  Date/Result

Prophylaxis prescribed: Yes _______  No _______

*All students must have a PPD, including those who have previously received BCG. A chest X-ray is required at the time of conversion and every 5 years thereafter (or less if required by the clinical site). Montefiore now requires any student with a positive PPD to have a negative X-Ray within one year. A copy of the radiology report must be attached to the Health Clearance Form. Students who convert to PPD positive must provide evidence that they are adhering to New York Department of Health protocol and CDC guidelines.

Recommendation for physical activities: Full activity_______  Limited activity________

If limited activity, specify limitations: __________________________________________

I certify that ____________________________ has had the required immunizations and that the physical examination and laboratory test results are within normal limits.

Healthcare Provider Name: ____________________________________________________

Healthcare Provider Signature: ________________________________________________

Healthcare Provider License # ____________  State: _______________________

Address: _____________________________________________________________

_________________________________________________________________________

Phone #: _________________________________________________________________

Email: _________________________________________________________________

Date of Exam: ________________________________
# LEHMAN COLLEGE DEPARTMENT OF NURSING

## IMMUNIZATION RECORD

*(To be completed by a licensed Healthcare Provider)*

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Vaccination Dates</th>
<th>Titre (Give exact numbers)</th>
<th>Date of Titre</th>
<th>Immune/Not Immune</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus-Diphtheria</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B* (HBV)</td>
<td></td>
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</tr>
</tbody>
</table>

**Influenza Virus Vaccine:** Submit a copy of your Vaccination Printout

<table>
<thead>
<tr>
<th>Date</th>
<th>Dose</th>
<th>Manufacturer</th>
<th>Lot Number</th>
<th>Expiration Date</th>
<th>Sticker Number</th>
<th>Provider Name/Location</th>
</tr>
</thead>
</table>

Vaccine Administrator: __________________________ Title: __________________ Signature: __________________

**Rubella titre is required.** This test will tell you if you have ever been exposed to Rubella or German Measles and have developed antibodies. Rubella usually results in a mild illness unless you are pregnant. Rubella during the first three months of pregnancy can result in congenital defects in the infant. If your Rubella titre is negative or less than 1:8, it means you have not developed antibodies to Rubella. A vaccine which is available through your physician will immunize you against Rubella. If your Rubella titre is positive, you do not need any additional immunization.

**Titres are** required for Mumps, Measles, and Varicella (Chicken Pox) unless proof of vaccination is available. If titres do not show immunity, the appropriate vaccinations are required.

**A Hepatitis antigen and antibody titre is required and should be done yearly.** It is strongly recommended that all students receive the Hepatitis B vaccine if they are not immune. If your titres indicate that you are not immune and you decline to be vaccinated, you must sign a declination statement which is available from the secretary in the Department of Nursing.

**Influenza Virus Vaccine is required and mandatory.** Influenza is contagious and you may be at risk for contracting the flu virus through occupational exposure to patients and others as a nursing student assigned to are for clients in a clinical setting. Some healthcare institutions may deny your clinical placement at their site without proof of the Influenza Vaccine.

Healthcare Provider Name: __________________________ License # __________________ State: __________

Healthcare Provider Signature: __________________________ Exam Date: __________
LEHMAN COLLEGE
THE CITY UNIVERSITY OF NEW YORK
DEPARTMENT OF NURSING

INFLUENZA VIRUS VACCINE*

I have been given the opportunity to receive the Influenza Vaccine and I have declined.

I understand that Influenza is contagious and that by declining this vaccine I may be at risk for contracting the flu virus. I also risk infecting others through my occupational exposure to patients and others as a nursing student assigned to care for clients in a clinical setting.

By declining, I understand that I must obtain written documentation from my healthcare provider verifying the medical condition that prevents me from receiving the Influenza Virus Vaccine and submit the original documentation with my completed Health Clearance Form to the Nursing Department.

I understand that some healthcare institutions may deny my clinical placement at their site if I do not receive the Influenza Vaccine.

I understand that I jeopardize my ability to complete my clinical requirements if the Nursing Department is unable to find a placement for me, and that I may have to withdraw from the Nursing Program.

Although I have declined at this time I understand that I can choose to receive the Influenza vaccination at a later date.

__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________

Student (Print)       Last Name       First Name

______________________________
Student’s Signature

__________________________________________________________
Date

I have advised the student named above of the risks associated with acquiring Influenza. I will provide/have provided documentation detailing the condition that prevents the above named student from receiving the Influenza Vaccine.

Healthcare Provider Name ____________________________ License # _____________ State: ____________
(print)

______________________________
Healthcare Provider Signature: ____________________________ Date: ____________
DECLINATION OF HEPATITIS B VACCINE*

I understand that, due to my occupational exposure to blood or other potentially infectious materials as a nursing student assigned to care for clients in the clinical setting, I may be at risk for acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine.

Although my Hepatitis antigen/antibody titre shows that I am not immune to Hepatitis B Virus, I decline Hepatitis B vaccination at this time. I understand that, by declinesing this vaccine, I could be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I understand that I can receive the vaccination series.

* Prior to signing this declination form, it is recommended that you discuss your decision with your primary care provider.