

## 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:** The Lehman College Department of Nursing (DON) requires a criminal background check and drug testing for admittance into the program as they are preconditions for students to participate in clinical rotations at the training health institutes. The drug testing and background check policies have been established to meet contractual requirements established by clinical facilities used by the DON for clinical placements of its nursing students.

**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 information at the top of each page. Check each page--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), drug test, background check, 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 15<sup>th</sup>
  - B. Spring Request –Deadline October 15<sup>th</sup>
  - C. Summer Request –Deadline March 15<sup>th</sup>

- 👍 **FAILURE 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: All clinical sites require a drug test and 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 your records or personal medical use. Nursing will not make copies for you.** Contact your health care provider, insurance carrier, or appropriate document issuer if you lose your documents or need copies.
- 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.

<b>A.</b>	<b>Department of Nursing's Health Clearance Form - Valid for 12 months from date of exam</b> Submit completed, signed original Health Clearance to Nursing – ALL NURSING STUDENTS <b>SUMMARY OF REQUIRED HEALTH CLEARANCE</b>	<i>Check-Off Completed</i>
	<b>1. Physical Examination annually.</b>	<input type="checkbox"/>
	<b>2. Laboratory Tests</b> – Evaluation of test results as “Normal” or “Abnormal” must be done by the licensed Healthcare Provider.	<input type="checkbox"/>
	<ul style="list-style-type: none"> <li>• CBC with Differential</li> <li>• Urinalysis with Microscopic exam</li> <li>• Hepatitis B Antigen/Antibody <u>Titre</u></li> <li>• Rubella <u>Titre</u> – <b>Positive</b> titre required (give exact numbers). Immunization required if titres are not immune.</li> <li>• <u>Varicella (Chicken Pox)</u> – <b>Positive</b> Titre required.</li> <li>• Measles, Mumps (if no documentation of immunizations available)</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	<b>3. Immunizations</b>	
	<ul style="list-style-type: none"> <li>• <b>Tetanus-Diphtheria</b> – Within 10 years (give exact date)</li> <li>• <b>PPD</b> – 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 (<b>or less if required by the clinical site</b>).               <ul style="list-style-type: none"> <li>▪ A copy of the radiology report must be attached to the Health Clearance Form.</li> <li>▪ Students who convert to PPD positive must provide evidence that they are being treated prophylactically, <b>as per New York State and CDC guidelines</b>, in order to continue in clinical.</li> </ul> </li> <li>• <b>Students who are PPD negative must have a repeat PPD prior to each clinical semester.</b></li> <li>• <b>Mumps</b> – Documentation of immunization or positive titre required.</li> <li>• <b>Measles</b> – Documentation of immunization or positive titre required.</li> <li>• <b>Vaccines</b> <ul style="list-style-type: none"> <li><b>Influenza Vaccine.</b> 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.</li> <li><b>Hepatitis B Vaccine.</b> If you decline this vaccine, then you must sign the Declination of Hepatitis B Vaccine (p 8).</li> </ul> </li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	<b>4. Additional requirements may be imposed</b> by specific agencies with which the Department of Nursing affiliates. These include, but are not limited to:	<i>Read &amp; Understood</i>
	<ul style="list-style-type: none"> <li>• Drug and alcohol screening</li> <li>• Background investigation including criminal record name search</li> <li>• Child Abuse and Maltreatment inquiry.</li> </ul>	<input type="checkbox"/>
<b>B.</b>	<b>Cardio-Pulmonary Resuscitation (CPR)</b> (also known as <b>Basic Cardiac Life Support (BLS/BCLS) for Healthcare Providers</b> - Source: The American Heart Association CPR classroom training – <b>valid for 2 years</b> - <b>ALL NURSING STUDENTS</b> .	<i>Check-Off Completed</i>
	<ul style="list-style-type: none"> <li>• Submit 1 copy of each side of your signed CPR card.</li> </ul>	<input type="checkbox"/>
<b>C.</b>	<b>Malpractice Liability Insurance - valid for 12 months</b> – <b>ALL RN-BS AND MASTER'S NURSING STUDENTS ONLY</b>	<i>Check-Off Completed</i>
	Nurses Service Organization (NSO): 800-247-1500. Apply online at: <a href="http://www.nso.com/professional-liability-insurance">http://www.nso.com/professional-liability-insurance</a> .	<input type="checkbox"/>
	<ul style="list-style-type: none"> <li>• Submit 1 copy of your Certificate of Insurance</li> </ul>	<input type="checkbox"/>
<b>D.</b>	<b>Consent to Release Documents form</b> - Submit signed original - <b>ALL NURSING STUDENTS</b>	<input type="checkbox"/>
<b>E.</b>	<b>RN License and Registration</b> – <b>ALL RN-BS, MASTER'S/POST-MASTER'S STUDENTS ONLY</b>	<input type="checkbox"/>
	<ul style="list-style-type: none"> <li>• Submit a copy of your current New York State RN license and registration.</li> </ul>	<input type="checkbox"/>
<b>F.</b>	<b>Application for Clinical Placement</b> – <b>ALL MASTER'S/POST-MASTER'S STUDENTS ONLY</b>	<input type="checkbox"/>
	<ul style="list-style-type: none"> <li>• See <a href="http://www.lehman.cuny.edu/academics/nursing/graduate-forms.php">Graduate Documents &amp; Forms</a> at <a href="http://www.lehman.cuny.edu/academics/nursing/graduate-forms.php">http://www.lehman.cuny.edu/academics/nursing/graduate-forms.php</a></li> </ul>	<input type="checkbox"/>

Completed  
by student  
(PRINT CLEARLY)

FirstName \_\_\_\_\_ MiddleInitial: \_\_\_\_ LastName: \_\_\_\_\_ Student ID# \_\_\_\_\_  
Program: Generic/Accelerated (B.S.)  RN-B.S  Master's/Post-Master's Certificate  Cohort/Online/Offsite: RN-BS  MD-RN  Master's

**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**)

Back trouble	Yes _____	No _____	Joint Disease	Yes _____	No _____
Asthma	Yes _____	No _____	Allergy	Yes _____	No _____
Tuberculosis	Yes _____	No _____	Ear Problems	Yes _____	No _____
Skin Problems.	Yes _____	No _____	Venereal Disease	Yes _____	No _____
Kidney Problems	Yes _____	No _____	Seizure Disorder	Yes _____	No _____
Ulcers	Yes _____	No _____	Mental/Emotional Problems	Yes _____	No _____
Cancer.	Yes _____	No _____	Hernia	Yes _____	No _____
Diabetes	Yes _____	No _____	Rheumatic Fever	Yes _____	No _____
Heart Murmur	Yes _____	No _____	Pneumonia.	Yes _____	No _____
High Blood Pressure	Yes _____	No _____	Low Blood Pressure.	Yes _____	No _____
Cardiac Disease	Yes _____	No _____	Drug Sensitivities	Yes _____	No _____

Describe any items checked YES above: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List previous serious illnesses/operations/hospitalizations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I understand that a drug test and criminal background check are required for participation in clinical rotation classes. 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: \_\_\_\_\_

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

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:** \_\_\_\_\_

**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: \_\_\_\_\_

Completed  
by student  
(PRINT CLEARLY)

FirstName \_\_\_\_\_ MiddleInitial: \_\_\_\_ LastName: \_\_\_\_\_ Student ID# \_\_\_\_\_  
 Program: Generic/Accelerated (B.S.)  RN-B.S  Master's/Post-Master's Certificate  Cohort/Online/Offsite: RN-BS  MD-RN  Master's

**LEHMAN COLLEGE DEPARTMENT OF NURSING**

**IMMUNIZATION RECORD**

(To be completed by a licensed Healthcare Provider)

	Vaccination Dates	Titre (Give exact numbers)	Date of Titre	Immune/Not Immune
<b>Tetanus-Diphtheria</b>				
<b>Measles</b>				
<b>Mumps</b>				
<b>Rubella</b>				
<b>Varicella</b>				
<b>Hepatitis B* (HBV)</b>				

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

Date	Dose	Manufacturer	Lot Number	Expiration Date	Sticker Number	Provider Name/Location

**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 care 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:** \_\_\_\_\_



Completed  
by student  
(PRINT CLEARLY)

FirstName \_\_\_\_\_ MiddleInitial: \_\_\_\_ LastName: \_\_\_\_\_ Student ID# \_\_\_\_\_  
Program: Generic/Accelerated (B.S.)  RN-B.S  Master's/Post-Master's Certificate  Cohort/Online/Offsite: RN-BS  MD-RN  Master's

**LEHMAN COLLEGE  
THE CITY UNIVERSITY OF NEW YORK  
DEPARTMENT OF NURSING**

**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 declining 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.

\_\_\_\_\_  
Student Print Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

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