Students enrolled in the Nursing Program at Rockland Community College are required to have their health care provider complete this form and submit it to Records & Registration by the due date.

**ANTIBODY TITERS:**

- **Rubella**: Date:_________ Level:_________ Status:_____________
- **Rubeola**: Date:_________ Level:_________ Status:_____________
- **Mumps**: Date:_________ Level:_________ Status:_____________
- **Varicella**: Date:_________ Level:_________ Status:_____________

**VACCINATIONS:**

- **Influenza** (on separate form)
- **Adult Diptheria/Pertussis/Tetanus (within last 10 years)**: Date:__________
- **Polio** (not required): Type:________________ Date:__________
- **Hepatitis B**: Date:_________________ or waiver ________________

**TUBERCULIN (TB) SKIN TEST (Mantoux/PPD): Must be done yearly.**

Date Placed:________ Date Read:________ Test Results:________ mm:________

Students with a positive Mantoux test must have a chest x-ray. Chest x-ray must be negative for TB.

- **Chest x-ray**: Date:________ Date Read:________ Results:____________
MEDICAL HISTORY: (Include present and past conditions)
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

CURRENT STATUS:

Height:_________ Lungs:_________ Hearing:_______________________________
Weight:_________ Heart:_________ Vision: ________________________________
B/P:___________ Other:__________________________________________________

BODY SYSTEMS: SIGNIFICANT FINDINGS:
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

CURRENT MEDICATIONS/TREATMENTS:
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

GENERAL IMPRESSION/ASSESSMENT:
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
HEALTH CARE PROVIDER RECOMMENDATION:

I have examined and determined that_____________________________ is free from any health impairment of potential risk to self, patients or staff which might interfere with the performance of his/her duties, including, but not limited to, the habituation or addiction to depressants, stimulants, narcotics alcohol or other drugs or “substances” which may alter behavior. He/she can engage without restriction in clinical activities that may include bathing, turning, lifting, positioning, transferring bed to chair/stretcher and back to bed of conscious and unconscious patients and assisting unsteady patients with ambulation.

Signature of Health Care Provider ____________________________________________________________ Date __________________

Stamp of Health Care Provider

Name of Health Care Provider (please print): ___________________________________________________
Address: ________________________________________________________________________________
Phone: ________________________________
INFORMATION RELEASE STATEMENT:

Name: ________________________________
Student ID #: _________________________

I, _________________________________, hereby authorize Rockland Community College to release the enclosed health history, physical assessment information to any clinical practicum site to which I am assigned while I am a student in the Nursing Program. I understand that I may revoke this authorization at any time and that this information will not be released to any other parties without my consent.

Signature __________________________ Date ______________

OCCUPATIONAL SAFETY & HEALTH ADMINISTRATION HEPATITIS STATEMENT:

To participate in a clinical rotation, Nursing and Allied Health students either must be vaccinated or sign the waiver to comply with OSHA regulations and Public Health Law.

Place a check mark next to the statement which applies to you and sign your name on the line provided.

______ I have been vaccinated against Hepatitis B as shown below:

Date 1: ____________ Date 2: ____________ Date 3: ____________

I understand that due to potential exposure to blood or other potentially infectious materials during clinical/laboratory experiences, I may be at risk of acquiring Hepatitis B (HBV).

However, at this time . . .

______ I choose/have chosen not to receive the Hepatitis B series of vaccinations

Signature __________________________ Date ______________

Hepatitis B Vaccinations and conformity with OSHA Blood Borne Pathogen Regulations are not Rockland Community College and State University of New York mandates. However, in order to participate in clinical rotations, affiliated health agencies may require students to either be vaccinated or sign the appropriate waiver to comply with OSHA regulations and Public Health law.

Signature __________________________ Date ______________