RCC Rockland Community College
STATE UNIVERSITY OF NEW YORK
Records & Registration

Health Record

Last Name _____ First Name _____ Initial ____

Student ID# _____ Date of Birth _____

Address _____ Apt. #_____

City _____ State _____ Zip _____

Phone # _____ Email _____@sunyrockland.edu

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:

Date1:_____ 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