LEHMAN COLLEGE DEPARTMENT OF NURSING

ANNUAL HEALTH CLEARANCE REQUIREMENTS


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 770, 771, 772, 773, 774, 775, 776, 809, 810, 811).**

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 uploaded to Castle Branch.

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**), and Liability Certificate of Insurance (RN-BS, Master's/Post-Master's, DNP students only) at the same time to the Nursing Department by the following deadlines: Advanced standing DNP students must carry NP Insurance.**

- **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

- **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.**
- **DRUG SCREENING MUST BE COMPLETED WITHIN 30 DAYS OF THE FIRST WEEK OF THE SEMESTER.**
- **SAVE ELECTRONIC 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.**
- **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.**

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 to Castle Branch. Check off the completion of your requirements below.
- **Save electronic copies of these documents for your own your records or personal medical use.** 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.
- Upload the health clearance, CPR for healthcare providers, drug testing, background check, influenza vaccine, COVID-19 proof of vaccination to Castle Branch.

A.	**Department of Nursing's Health Clearance Form - Valid for 12 months from date of exam** Submit completed, signed original Health Clearance to Nursing – **ALL NURSING STUDENTS**	*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). Vaccination required if titres are not immune.	☐
	• Varicella (Chicken Pox) – Positive Titre required.	☐
	• Measles, Mumps – Positive Titre required.	☐
	3. **Immunizations**	
	• **Tetanus-Diphtheria** – Within 10 years (give exact date)	☐
	• **PPD** – All students must have a negative QuantiFERON-TB Gold test,, 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**. Influenza vaccine is required. 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**. It is strongly recommended that all students receive the Hepatitis B vaccine. If you decline this vaccine, then you must sign the Declination of Hepatitis B Vaccine (p 8). • **COVID-19 Vaccine. Nursing students must be completely vaccinated to participate in clinical experiences. This is a requirement of the clinical agencies. If you are not vaccinated, you will have to withdraw from the program. If you have a religious or medical reason you must contact the Lehman Vaccination Action, Refer to the CUNY policy at: https://www.cuny.edu/coronavirus/ Please note, clinical agencies may not accept the medical exemption or religious exemption in their agency. The Nursing Department must adhere to the agency's policies.** • **Vaccination(s) are required for titres that are not immune (unless contraindicated).**	☐ ☐
	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. • Fit testing	*Read & Understood* ☐
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.	*Check-Off Completed* ☐

		Check-Off Completed
C.	**Malpractice Liability Insurance - valid for 12 months – ALL RN-BS AND GRADUATE NURSING STUDENTS** Nurses Service Organization (NSO): 800-247-1500. Apply online at: http://www.nso.com/professional-liability-insurance. • 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	☐

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:_____ _____ Conversion Date _____ Date/Result _____

QuantiFERON-TB Gold Test _____
Date/Result

TB Prophylaxis prescribed: Yes _____ No _____

*All students must have a PPD, or a negative QuantiFERON-TB Gold test, 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 or have a positive QuantiFERON-TB Gold test must provide evidence that they are adhering to New York Department of Health protocol and CDC guidelines for appropriate treatment.

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)

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

Influenza Virus Vaccine: Submit a copy of your Vaccination Printout

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

Vaccine Administrator: _____ Title: _____ Signature: _____

COVID-19 Vaccinations: Submit acopy of COVID-19 vaccination card

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

Titres are required for Mumps, Measles, Rubella, Varicella (Chicken Pox), and Hepatitis B. If titres do not show immunity, the appropriate vaccinations are required.

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.

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: _____

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.**