MOLLOY COLLEGE SCHOOL OF NURSING
PHYSICAL FORM

Molloy College – Barbara H. Hagan School of Nursing
Nursing Learning Lab (516) 323-3751 or 3752
1000 Hempstead Ave., Rockville Centre, New York 11571-5002

***Anticipated Class next semester*:**

________ ________
Course Section

***Last Name*_____________________ *First Name* _______________________ *ID#*_____________________**
***Maiden Name*____ *Date of Birth*_______________**
***Address* ____ *Male* _______ *Female*________**
____ *Phone* _____________________

Required on Initial Physical Only: TITRES NEED TO BE DONE ONE TIME ONLY

LAB REPORTS MUST BE ATTACHED FOR EACH TITRE!

****NEGATIVE TITRES FOR RUBELLA, RUBEOLA, MUMPS, VARICELLA AND HEPATITIS B, REQUIRE A BOOSTER VACCINE AND A FOLLOW UP TITRE**

Rubella Titre **Value** _______________ **Result:** ________________ **Booster**_______________ **Follow up Titre** _______________

Rubeola Titre **Value** _______________ **Result:** ________________ **Booster** _______________ **Follow up Titre** _______________

Varicella Titre **Value** _______________ **Result:** ________________ **Booster** _______________ **Follow up Titre** _______________

Mumps Titre **Value** _______________ **Result:** ________________ **Booster** _______________ **Follow up Titre** _______________

HepB Titre **Value** _______________ **Result:** ________________ **Booster** _______________ **Follow up Titre** ______________

HISTORY OF VACCINATIONS:

MMR #1 __________________ **MMR #2**__________________ **VARICELLA #1** ___________________ **VARICELLA #2**___________________

Hepatitis B Vaccine: **HepB #1** _________________ **HepB #2** ___________________ **HepB #3** ____________________

NURSING STUDENTS ARE TO BE IMMUNIZED WITH HEPATITIS B VACCINE PRIOR TO THE BEGINNING OF CLINICAL PRACTICE OR MUST SIGN A DECLINATION STATEMENT.

DECLINATION STATEMENT

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been informed of the need to be vaccinated with Hepatitis B Vaccine. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccination, I continue to be at risk of acquiring Hepatitis B, a serious disease.

Name (Print): ____

Date: ____________________ **SIGNATURE:** ____

Diptheria/TetanusPertussis: [Within Last 10 Years] (Tdap)______________ **(Td)**_______________

If, as an adult you haven't had a vaccine that contains pertussis (whooping cough) one of **the doses you receive needs to have pertussis in it.**

-OVER-

I certify that ______________________________
(PRINT NAME OF STUDENT/FACULTY MEMBER)

Is in good health as determined by a recent physical examination of sufficient scope to ensure that he or she is free from health impairments which may be of potential risk to patients or other personnel or which may interfere with the performance of his or her duties, including habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter individual behavior. This individual is able to participate in clinical learning experiences as a student of Nursing.
I have identified the following:

B.P.:___________________

Vision: ____________________ Hearing: ____________________

Allergy To Latex: Yes: _____ No: _____ Other Allergies: __________________

Illnesses: ____

Injuries: ____

Restrictions on activity: ____

Medications: ____

Disabilities: ____
****Students with disabilities are considered on an individual basis. Students must be able to meet program objectives.**

Name of Health Care Provider:

____

(Stamp Is Required)

Address: ____ Phone: ______________________________

Date: ____________________________________

HEALTH CARE PROVIDER
SIGNATURE: ____

RELEASE OF HEALTH RECORDS

I, the undersigned, authorize release of information from my Health Record to affiliating clinical agencies.
PLEASE SIGN BELOW:

SIGNATURE: ____ **Date** ___________________
Student name

MOLLOY COLLEGE SCHOOL OF NURSING
PPD FORM

Molloy College – Barbara H. Hagan School of Nursing
Nursing Learning Lab (516) 323-3751 or 3752
1000 Hempstead Ave., Rockville Centre, New York 11571-5002

***Anticipated Class next semester*:**
_______ _______
Course ***Section***

***Last Name*_____________________ *First Name* ______________________ *ID#*______________________**
***Maiden Name*_______________________________________ *Date of Birth*_______________**
***Address* ____ *Male* _______ *Female* _______**
____ *Phone* _____________________

- ***ONE* OF THE FOLLOWING MUST BE COMPLETED WITHIN THE PAST 12 MONTHS.**
  If positive results, submit physician clearance on letterhead.

1. **PPD – Tuberculin Test (PPD intradermal only) [MUST BE READ 48 – 72 HOURS LATER]**

Date Implanted: ________________ Read: __________________ Result: _____________________

OR

2. **QuantiFERON TB Gold Result ______________- Lab Sheet Must Be Attached**

3. **POSITIVE FINDINGS OF ALL TUBERCULOSIS TESTS REQUIRE A NEGATIVE CHEST XRAY REPORT. XRAY REPORT MUST BE ATTACHED:**

Date: ________________________________ Result: _____________________________________

Name of Health Care Provider: ____

____ __________________________________
Address **Phone Number**

STAMP IS REQUIRED

MOLLOY COLLEGE
Barbara H. Hagan School of Nursing
FLU VACCINE FORM

PLEASE PRINT

____

Student Name ***Molloy ID Number***

____

E-Mail Address ***Phone Number*** ***Course & Section***

Clinical Placement ________________________________
NAME OF HOSPITAL/FACILITY ***Fall*** _____ ***Spring*** _____

Manufacturer of Vaccine ______________________

Lot Number of the Vaccine ______________________

Dose Administered ______________________

Date Administered ______________________

____

Name of Provider ***License Number*** ***Stamp***

____

Address of Provider

-Make sure to keep a copy for your records-