MOLLOY COLLEGE
DIVISION OF NURSING

CHECKLIST – Everything must be completed

1. _____ PHYSICAL EXAMINATION, completed on a Division of Nursing Physical Form. Must be signed, stamped and dated by a Health Care Provider and include:
   • ALL STUDENTS MUST HAVE QUANTIFERON TB TEST
   Or
   **ON INITIAL PHYSICAL ONLY** YOU MUST PROVIDE DOCUMENTATION OF TWO (2) PPD’S WITHIN 365 DAYS OF EACH OTHER -EACH SUBSEQUENT PHYSICAL REQUIRES ONLY ONE (1) PPD. PPD-MUST BE READ BETWEEN 48 AND 72 HOURS
   Please refer to: [http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5202a2.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5202a2.htm)
   • Chest X-ray if Quantiferon or PPD is positive. Copy of Chest X-ray must be attached to the Physical.
   • Laboratory Titre Reports (LAB SHEETS) for: Rubella, Rubeola, Varicella Mumps- Numerical Values Required

   **PHYSICAL AND PPDs MUST BE DONE YEARLY AND SUBMITTED TO NICOLE BENSON- HAGAN RM. 205**

   **Physical Due Dates:**
   - **Summer Semester:** Completed after March 15th and submitted before April 15th
   - **Fall Semester:** Completed after June 15th and submitted before July 15th
   - **Spring Semester:** Completed after November 1st and submitted before December 1st

2. ____ CPR-Cardio pulmonary resuscitation certification must be completed…. CPR cards must be submitted with your Physical Information. Accepted Program: American Heart Association – BLS for Health Care Providers

3. ____ Order your Molloy Nursing Uniform and white professional shoes.

4. ____ Order Name Pin and Molloy College School Patch which is to be sewn to the left sleeve of the uniform. Order early enough to be ready before your clinical begins.

5. ____ Obtain: a) Stethoscope (Dual Head) b) Sphygmomanometer – Blood Pressure Machine c) Watch with second hand

6. ____ LPN, RN Students must also submit a copy of their BLS, License Registration Certificate and Malpractice Insurance to Nicole Benson – Hagan Room 205

7. ____ Review the Molloy College Nursing Handbook and review policies and health requirements.

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Attention All Nursing Students

For clarification or questions about:

The Checklist
Physical Forms
Latex Allergy Form
Flu Vaccine Form
Student Uniform Information

Please call:

Nicole Benson (516) 323-3751
Krissy Hill (516) 323-3752

Barbara H. Hagen Center for Nursing Room 205

Office Hours:
Monday - Friday 8am – 4pm
Students must purchase a uniform/patch/name pin at:

LAKEVILLE UNIFORMS or LIFE UNIFORMS

In addition to the uniform, you will need white shoes and stockings (women), stethoscope (Dual Head/Professional color), sphygmomanometer (B/P machine) and a watch with second hand. You may purchase equipment and shoes at Lakeville Uniforms/Life Uniforms or on your own.

Female Uniforms:
  Top: Cherokee       # 2878
  Pants: Cherokee     # 4001
  OR
  Dress – Barco       # 4801

Male Uniforms:
  Top:  Adar Jacket   # 607
  Pants: Landau       # 8550

Name Pins:
  Red with white lettering
Name Badge should read: Example…M. Smith, N.S.
  Molloy College Student

Molloy Patch

Review the Nursing Student Handbook regarding Dress Code.

***Bring this letter with you to the store!!!***

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MOLLOY COLLEGE DIVISION OF NURSING

PHYSICAL FORM

Return form to: Molloy College – Division of Nursing
Barbara H. Hagan Center for Nursing - Room 205
1000 Hempstead Ave., P.O. Box 5002 Rockville Centre, NY 11571-5002

Anticipated Class next semester:

<table>
<thead>
<tr>
<th>Class</th>
<th>Section</th>
</tr>
</thead>
</table>

Last Name: ____________________________  First Name: _____________________     ID# _____________________

Maiden Name: ____________________________________    Date of Birth:  __________       Male ____ Female _____

Address __________________________________________

Phone: _____________________

Titres Required on Initial Physical Only:

LAB REPORTS MUST BE ATTACHED FOR EACH TITRE!

Rubella Titre          Value __________________Result: ______________________
Rubeola Titre         Value __________________Result: ______________________
Varicella Titre       Value _________________ Result: _______________________
Mumps Titre          Value _________________ Result: _______________________

NEGATIVE TITRES FOR RUBELLA, RUBEOLA AND MUMPS REQUIRE PROOF OF TWO (2) MMR’s, A NEGATIVE
VARICELLA TITRE REQUIRES PROOF OF TWO (2) VARICELLA VACCINES.

MMR #1- _______________________________________       MMR #2 -_____________________________________________

VARICELLA #1- ___________________________________ VARICELLA #2 -________________________________________

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.

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

Hepatitis B Vaccine: 1) Date _______________  2) Date _______________  3) Date _______________

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: ___________________________________________

-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/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/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: __________________________

Health Care Provider Signature: ________________________________________ Date:  __________________________

RELEASE OF HEALTH RECORDS

I, the undersigned, authorize release of information from my Health Record to affiliating Clinical Agencies.

PLEASE SIGN BELOW:

Signature of Student/Faculty: __________________________________________ Date: __________________________

COPY OF BLS/CPR CARD MUST BE SUBMITTED

PLEASE SUBMIT COPIES OF YOUR ORIENTATION PACKETS TO YOUR FACULTY

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MOLLOY COLLEGE DIVISION OF NURSING
PHYSICAL FORM

Return form to: Molloy College – Division of Nursing
Barbara H. Hagan Center for Nursing Room 205
(516) 323-3751
1000 Hempstead Ave., P.O. Box 5002 Rockville Centre, NY 11571-5002

Anticipated Class Next Semester: ______________________
Class _______ Section _______

Last Name: ___________________ First Name: ___________________ ID#: ____________
Maiden Name: ______________ Date of Birth: ____________ Male _____ Female _____
_________________________________________________ Phone _________________

On Initial Physical Only You Must Provide Documentation of Two (2) PPDs Within 365 Days of
Each Other – Each Subsequent Physical Requires Only One (1) PPD.

• Two Step PPD - Tuberculin Test (PPD intradermal only) [MUST BE READ 48 – 72 HOURS
LATER]

Date Implanted: ________________ Read: __________________ Result: ___________________

*SECOND (2ND) PPD IS REQUIRED AND SHOULD BE PLANTED 1-3 WEEKS AFTER FIRST PPD*

Date Implanted: ________________ Read: __________________ Result: ___________________

OR

• QuantIFERON TB Gold Result ____________ - Lab Sheet Must Be Attached

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

Date: ________________________________ Result: ________________________________

Name of Health Care Provider: _____________________________________________
Name
Address ____________________________________________ Phone Number

(STAMP IS REQUIRED)
MOLLOY COLLEGE
DIVISION OF NURSING
Latex Allergy Policy

Background: Over the last ten years, latex allergy has become a serious healthcare problem. Experts have described it as a disabling occupational disease among healthcare workers (American Nurses Association, 1997).

The allergic reaction to latex is evoked by direct contact with products containing latex rubber or by inhaling powder from latex gloves. Responses may range in severity from a rash to asthma attacks to death from anaphylaxis (New York State Nurses Association, 1999).

The increased need to don gloves in both medical and non-medical settings has increased the prevalence of latex allergies. A 1997 alert published by the National Institute of Occupational Safety (NIOSH) indicated that about 1% to 6% of the general population and 8% to 12% of regularly exposed healthcare workers are sensitized to latex. These statistics indicate that an increasing number of entering nursing students may already have a latex sensitivity. Beginning one’s professional life with a latex allergy presents unique problems for students and faculty.

In light of this growing problem the Division of Nursing has developed the following policy related to latex exposure.

Initial Steps: All Molloy Division of Nursing Student and Faculty History and Physical Forms to have a category, which indicates Latex Allergy. The healthcare provider completing the form must specifically respond to this item.

Follow-Up: In those instances where a latex allergy has been indicated, faculty/student will need to be contacted by Health Services: The following actions should be initiated:
- Faculty/Student will be given literature on latex allergies
- Faculty/Student will be counseled regarding acceleration of sensitivity with repeated exposures
- Faculty/Student will be encouraged to wear a Medi-Alert bracelet as suggested by NIOSH
- Faculty/Student acknowledgement of this policy will be kept on file in department

Agency Contact: The faculty/student will be responsible for sharing information about themselves regarding latex allergy with the respective clinical agency.

I am a faculty member/student in the Molloy College Division of Nursing. I have read the Molloy College policy concerning Latex Allergy.

☐ I do not have any allergy to latex, or

☐ I have a latex allergy and I have previously so notified Molloy College. I am fully aware of the dangers arising out of exposure to latex and I agree to exercise appropriate caution. I hereby release Molloy College, its Board of Trustees, officers and administrators and employees from any claim or liability arising out of my exposure to latex either on the campus of Molloy College or in any clinical setting.

Print Name

Signature __________________________ Date ________________

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FLU VACCINE FORM – PLEASE PRINT

________________________________________________              ______________
Student Name              ID Number

________________________________________________              ______________
E-Mail Address              Phone Number              Class & Section

Clinical Placement: ______________________________________________________
Name of Hospital/Facility

Manufacturer of Vaccine: _______________________________
Lot Number of the Vaccine: _______________________________
Dose Administered: _______________________________
Date Administered: _______________________________

_______________________________    ______________________
Name of the Provider       License Number

_________________________________________________________________________
Address of the Provider

STAMP:

*YOU MUST SUBMIT ONE (1) COPY TO THE NURSING LAB, AND KEEP ONE (1) FOR YOURSELF.

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