The following is a checklist of requirements for attending clinical practice at Nursing Homes, Hospitals and Community Agencies. Each and every item must be completed:

1. _____ Physical examination, completed on a **DIVISION OF NURSING PHYSICAL FORM. FORM MUST BE SIGNED, STAMPED AND DATED BY HEALTH CARE PROVIDER AND MUST INCLUDE:**
   - **ALL STUDENTS MUST HAVE QUANTIFERON TB TEST**
   - **OR**
   - **ON INITIAL PHYSICAL ONLY YOU MUST PROVIDE DOCUMENTATION OF TWO PPDs 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-A COPY OF CHEST X-RAY REPORT MUST BE ATTACHED TO PHYSICAL FORM
   - Laboratory Titre Reports (**LAB SHEETS**) for: Rubella; Rubeola; Varicella; Mumps- **Numerical Values Required**

**Physicals are due:**
- **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.

**PHYSICAL AND PPDs MUST BE DONE YEARLY AND SUBMITTED TO JEANNE RYAN-CASEY RM. 224**

2. _____ CPR-Cardio pulmonary resuscitation certification must be completed…. CPR cards must be submitted with your Physical Information to Casey 224.
   - Accepted Program: **American Heart Assoc. – 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/Professional Color)
   - b) Sphygmomanometer – Blood Pressure Machine
   - c) Watch with second hand

6. _____ LPN, RN & GRADUATE NURSING STUDENTS MUST ALSO SUBMIT A COPY OF THEIR BLS, LICENSE REGISTRATION CERTIFICATE AND MALPRACTICE INSURANCE – GRADUATE STUDENTS MUST ALSO SUBMIT A COPY OF THEIR CERTIFICATE OF INFECTION CONTROL TO JEANNE RYAN –CASEY RM. 224.

7. _____ Review the Molloy College Nursing Handbook and review policies and health requirements.
Attention All Nursing Students

For Clarification of the Attached Checklist, Physical Form, Latex Allergy Form, Flu Vaccine Form, and Student Uniform Information please come to Casey 224 between the hours of 8am - 4pm

Or

Call Jeanne Ryan at (516) 323-3751 – or-

Krissy Hill at (516) 323-3752

Between 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 Students

Molloy Patch

Review the Nursing Student Handbook regarding Dress Code.

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

Revised Fall 2013
MOLLOY COLLEGE DIVISION OF NURSING
PHYSICAL FORM

Return form to: Molloy College – Division of Nursing
Nursing Learning Lab (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_________________
Address _________________________
_________________________________________________

Date of Birth ____________________  Male ______  Female ______  Phone _________________

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

LAB REPORTS MUST BE ATTACHED FOR EACH TITRE!

Rubella Titre  Value ______________ Result: _____________________
Rubella Titre  Value ______________ Result: _____________________
Varicella Titre Value ______________ Result: _____________________
Varicella Titre Value ______________ Result: _____________________
Mumps 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.

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

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: ______________________________________

- OVER -
I certify that __________________________

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 __________________________

COPY OF BLS/CPR CARD MUST BE SUBMITTED

PLEASE SUBMIT COPIES OF YOUR ORIENTATION PACKETS TO YOUR FACULTY AND TO KRISSEY HILL-CASEY 224
MOLLOY COLLEGE DIVISION OF NURSING
PPD FORM

Return form to: Molloy College – Division of Nursing
Nursing Learning Lab (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_______________
Address __________________________________________                           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)
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

Rev. Fall 2013
Student Name  ID Number

E-Mail Address  Phone Number  Class & Section

Manufacturer of Vaccine  

Lot Number of the Vaccine  

Dose Administered  

Date Administered  

Name of Provider  License Number  Stamp

Address