Prior to taking your clinical practicum courses, you are required to have the following:

1. Current New York State license registration certificate.
2. Malpractice insurance appropriate to your program (Registered Nurse or Nurse Practitioner - Addend to: NP Student) with coverage of $1,000,000 per claim/ $3,000,000 aggregate.
3. Cardio-Pulmonary Resuscitation (CPR) certification. **MUST BE BLS**.
   - If course is taken online, evidence of skills testing is also required. Accepted Program: American Heart Association – BLS for Health Care Providers.
5. A **completed** Division of Nursing Physical Form. (See attached) **Attach titre lab sheets**!

**PHYSICALS:**
Two copies are required... **KEEP ONE COPY FOR YOUR RECORDS.** Copies will not be returned to you. Clinical areas require presentation of completed physical. You are required to present this physical upon demand. Please be prepared. All medical documents are to be submitted to Siena Hall- Rm. 101 per schedule below.

There will be **NO** reminder. It is your responsibility to hand in an annual Physical and PPD whether or not you are enrolled in a clinical course. If you submit your physical on November 1st the following year another Physical and PPD will be due on November 1st.

It is further your responsibility to send all interim renewals to Barbara H. Hagan School of Nursing, Room 205 (i.e., CPR, PPD, mal-practice, License, etc).

1. **Physicalls:** Physical examination, completed on a **SCHOOL 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
   - **Two step PPD (2nd PPD must be planted 1-3 weeks after first PPD) OR**
   - **You can avoid a 2nd PPD if you can provide documentation of previous PPD within the past 365 days.**
     - 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 Quantifieron 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
2. **Immunizations:**
   All immunization information must be documented on all physicals. Leave no blank areas on Physical Forms. All dates for Hepatitis must be included.
   **Note:** Once titres are completed and document immunity, they need not be repeated for subsequent physicals.

3. **Clinical Agency Affiliation Health Requirements:**
   Individual clinical agency affiliates may require additional medical tests for students entering their agencies. A Drug Screening Test and/or finger printing may be required.

4. **Health Insurance:**
   Students are expected to carry their own health insurance.

5. **Late Fee:**
   A fee of $50.00 will be charged to process late physical materials.

6. **Photo ID Badge**
   Students are required to wear an up-to-date Molloy College photo ID badge during all clinical/practicum experiences. Each semester, ID must be updated.
   Photo ID badges are issued by Department of Public Safety during the first and second week of classes. See e-mail notice at start of semester for hours or call Ext. 3506.

7. **Uniform for Clinical Experience**
   Graduate students are to wear plain white lab coat (no affiliation badges of any kind are to be displayed on the lab coat). MOLLOY STUDENT PHOTO ID IS TO BE DISPLAYED.

Submit all physical materials to The Barbara H. Hagan School of Nursing Rm. 205. **Students will not be permitted in Clinical settings until all the necessary documents are on file in the Nursing Division.**
Attention All Nursing Students

For Clarification of the Attached Checklist, Physical Form, PPD Form, Latex Allergy Form & Flu Vaccine Form please come to The Barbara H. Hagan School of Nursing, Rm. 205 between the hours of 9am - 5pm.

Or

Call: Helene Rogers
(516) 323-3738
hrogers@molloy.edu
MOLLOY COLLEGE
THE BARBARA H. HAGAN SCHOOL OF NURSING
PHYSICAL FORM

Return form to: Molloy College
Barbara H. Hagan School of Nursing Rm. 205 516-323-3738
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 __________________________________________

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: __________
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 ______________________________________________________

Diabetes/Tetanus/Pertussis: [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
decline 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: __________________________________________
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
Return form to: Molloy College
Barbara H. Hagan School of Nursing Rm. 205  516-323-3738
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 ________________________________

• QuantiFERON TB Gold Result _______ -Lab Sheet Must Be Attached

OR

• 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 MUST BE PLANTED 1-3 WEEKS AFTER FIRST PPD*

Date Implanted: _______________ Read: _______________ Result: __________________

OR

You Can Avoid a 2nd PPD If You Can Provide Documentation of Previous PPD Within The Past 365 Days

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
THE BARBARA H.HAGAN SCHOOL 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 Barbara H. Hagan School 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. Spring 2011
Rev. 8/2016 cl
# FLU VACCINE FORM

<table>
<thead>
<tr>
<th>Student Name</th>
<th>ID Number</th>
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**Seasonal Flu Vaccine**

- **Manufacturer of Vaccine**: ________________
- **Lot Number of the Vaccine**: ________________
- **Dose Administered**: ________________
- **Date Administered**: ________________

**Name of Provider**: ________________  
**Office Seal**: ________________

**Address of Provider**: ________________