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

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

(Stamp is Required)

Rev. Spring 2016
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

Rev. Spring 2016
MOLLOY COLLEGE
DIVISION OF NURSING

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.

Rev. Spring 2016