CHECKLIST OF REQUIREMENTS
FOR ATTENDING CLINICAL PRACTICE HOSPITALS AND COMMUNITY AGENCIES

Each item must be completed:

1. _____ Physical examination using the SCHOOL OF NURSING PHYSICAL FORM. FORM MUST BE SIGNED, STAMPED AND DATED BY PROVIDER AND INCLUDE:
   - On initial physical for NUR 2090 students, you must provide documentation of two PPDs implanted within 365 days of each other or a Quantiferon blood test.
   - Each subsequent physical requires only one PPD or Quantiferon blood test
   - Laboratory Titer Reports (LAB SHEETS) for Rubella, Rubeola, Varicella, Mumps and Hepatitis B. Numerical Values for each are required
   - Physicals/PPD must be submitted annually to Castle Branch at www.castlebranch.com
     Any questions uploading your documents please call 1-888-723-4263

   **Summer Semester:** Upload Molloy College Physical documents to Castle Branch on or before April 15th.
   **Fall Semester:** Upload Molloy College Physical documents to Castle Branch on or before July 15th.
   **Spring Semester:** Upload Molloy College Physical documents to Castle Branch on or before December 1st.

2. _____ CPR-Cardio pulmonary resuscitation certification must be completed. **No online course will be accepted.**
   - For AHA classes please call Molloy Continuing Education at 516-323-3550 or 3559 (Siena Room 106)
   - CPR cards must be submitted (Make copy of front and back) with your Physical Information.
   - Acceptable Courses provided by: American Heart Assoc. – BLS for Health Care Providers
     American Red Cross – BLS for the Professional Rescuer

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

4. _____ Order Name Pin and Molloy College School Patch. Sew patch on left sleeve of the uniform.

5. _____ Purchase Dual Head Stethoscope in either black or dark blue color
   a Sphygmomanometer to take blood pressure and a watch with a sweep second hand.

6. _____ LPN and RN NURSING STUDENTS MUST ALSO SUBMIT A COPY of LICENSE, REGISTRATION CERTIFICATE AND MALPRACTICE INSURANCE

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

8. _____ Signed HIPPA form

9. _____ FLU vaccines are valid for the influenza season (generally August to June of following year)
   * FLU must be submitted to Castle Branch as well as to Hagan 205 by October 1st.
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 Hagan Rm 205 between the hours of 9 am – 4:30 pm

Or

Call Krissy Hill at (516) 323-3752
Or
Jeanne Dazzo at (516) 323-3666

Between 9 am – 4:30 pm
UNIFORM REQUIREMENTS

Lakeville Uniforms  Life Uniform
271-11 Union Turnpike  249 Old Country Road
New Hyde Park, NY  11040  Carle Place, NY  11514

(718)-343-8947  Ask for: Judy Chu

Students must purchase a uniform/patch 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  # 2880
Pants: Cherokee  # 4200
OR
     Dress – Barco  # 4801

Male Uniforms:
Top:  Med Man  # 1373
Pants:  Landau  # 8550

Molloy Patch: To be sewn on left sleeve

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

Review the Nursing Student Handbook regarding Dress Code.

***Bring this letter with you to the store!!!***
MOLLOY COLLEGE
THE BARBARA H. HAGAN SCHOOL OF NURSING & HEALTH SCIENCES

PHYSICAL FORM

Molloy College – Barbara H. Hagan School of Nursing
Hagan 205 Krissy Hill (516) 323-3752 or Jeanne Dazzo (516) 323-3666
1000 Hempstead Ave., Rockville Centre, New York 11571-5002

Anticipated Class
next semester:

Course Section

Required on Initial Physical Only: TITERS NEED TO BE DONE ONE TIME ONLY
LAB REPORTS MUST BE ATTACHED FOR EACH TITRE!

Rubella Titer Value ________ Result: __________ Date ________ Booster ________ Follow Up Titer ________
Rubeola Titer Value ________ Result: __________ Date ________ Booster ________ Follow Up Titer ________
Varicella Titer Value ________ Result: __________ Date ________ Booster ________ Follow Up Titer ________
Mumps Titer Value ________ Result: __________ Date ________ Booster ________ Follow Up Titer ________
HepB Titer Value ________ Result: __________ Date ________ Booster ________ Follow Up Titer ________

HISTORY OF VACCINATIONS: Please provide immunization dates if Titers are Equivocal or Negative

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
If HepB titer is Negative or Equivocal and you DO NOT have record of your immunization you must sign Declination.

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.
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:

________________________________________

Address: ___________________________________________ Phone: ______________________

Date: ______________________

HEALTH CARE PROVIDER
SIGNATURE: __________________________________________

________________________________________

(Stamp Is Required)

Address: ___________________________________________ Phone: ______________________

Date: ______________________

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
**ONE OF THE FOLLOWING MUST BE COMPLETED WITHIN THE PAST 12 MONTHS.**
If positive results, submit physician clearance on letterhead. A **TWO STEP PPD** is required for first time clinical students *only*.

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

   Date Implanted: ______________ Date Read: ______________ Result: ______________

   *2nd PPD IS REQUIRED AND SHOULD BE IMPLANTED WITHIN 364 DAYS OF THE 1st PPD*

   Date Implanted: ______________ Date Read: ______________ Result: ______________

   **OR**

2. QuantiFERON TB Gold Result: ________ Date: __________ 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: __________________________________________

   _______________________________ ________________________________
   Address                          Phone Number

   **STAMP IS REQUIRED**
Background: 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 less than 1% of the general population and 8% to 17% of regularly exposed healthcare workers are sensitized to latex (American Latex Allergy Assoc., 2016). 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 challenges for students and faculty.

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

Initial Steps: All Molloy School 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 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

Print Name

Signature Date

Updated Summer 2019
Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal Amendment to the Internal Revenue Code of 1986 concerning health insurance and issues in combating fraud and abuse in health insurance and health care delivery.

- HIPAA provides for standardization of the interchange of medical data
- Protects patient privacy
- Protects security of patient data

FERPA stands for Family Educational Rights and Privacy Act (Buckley Amendment). Passed by Congress in 1974 the Act grants four specific Rights to the student.

- The right to see the information the institution is keeping on the student
- The right to seek amendment to those records and in certain cases append a statement to the record
- The right to consent to disclosure of his/her records
- The right to file a complaint with the FERPA office in Washington

Confidentiality provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as well as provisions of the Family Educational and Privacy Act of 1974 (FERPA) have been explained to me and I fully understand them.

I hereby authorize release of information from my student health record to affiliated clinical agencies as indicated below in accordance with all relevant State and Federal confidentiality laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Federal Educational Rights and Privacy Act of 1974 (FERPA).

Name (Please print)

Signature __________________________________________________________________________ Date __________________________________________________________________________

_Baldwin High School District_  __North Shore/LIJ Health Care Systems_  __Visiting Nurse Association of Long Island_
_Broadlawn Manor Nursing & Rehab. Center_  __North Shore University Hosp. at Manhasset_  __Visiting Nurse Service, Inc._
_Children & Family Services_  __North Shore University Hosp. at Glen Cove_  __Visiting Nurse Service of New York City_
_CNR Health Care_  __North Shore University Hosp. at Plainview_  __Winthrop Home Care_
_Community Health Centers/Nassau Health Corp._  __North Shore University Hospital at Huntington_  __Winthrop Poison Control_
_Good Samaritan Hospital Medical Center_  __North Shore University Hospital at Syosset_  __Winthrop University Hospital_
_Good Shepherd Hospice_  __Peninsula Hospital Center_  __Any other clinical agencies__
_Holliswood Hospital_  __St. Francis Hospital_  ________________________________
_Huntington Hospital_  __St. Johns Episcopal Hospital, South Shore_  ________________________________
_Jamaica Hospital_  __St. Mary’s Hospital for Children_  ________________________________
_John T. Mather Memorial Hospital_  __South Nassau Communities Hospital_  ________________________________
_Komanoff Center for Rehabilitative Medicine_  __South Nassau Home Care_  ________________________________
_Long Beach Hospital Home Care_  __South Oaks Hospital_  ________________________________
_Long Beach Medical Center_  __The Center for Developmental Disabilities_  ________________________________
_Long Beach Schools_  ________________________________________________________________
_Mercy Medical Center_  ________________________________________________________________
_Nassau Boces Teen Age Parenting Program_  ________________________________________________________________
_Nassau University Medical Center_  ________________________________________________________________
_New Hyde Park Schools_  ________________________________________________________________
_NY Hospital Medical Center of Queens_  ________________________________________________________________

Any other clinical agencies
# FLU VACCINE FORM

**PLEASE PRINT**

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Molloy ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-Mail Address</td>
<td>Phone Number</td>
</tr>
</tbody>
</table>

*Entire form must be completed*

- Manufacturer or Company Name of Vaccine
- Lot Number of the Vaccine
- Expiration Date
- Dose Administered
- Date Administered

**Placement**
- [ ] Right Deltoid
- [ ] Left Deltoid

<table>
<thead>
<tr>
<th>Name of Provider</th>
<th>License Number</th>
<th>Stamp</th>
</tr>
</thead>
</table>

**Address of Provider**

**DUE BY OCTOBER 1st**

Summer 2019