MOLLOY COLLEGE
THE BARBARA H. HAGAN SCHOOL OF NURSING & HEALTH SCIENCES

PHYSICAL FORM 2021-2022

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***

***Last Name*_____ *First Name* _____ *ID#*_____**
***Maiden Name*_____ *Date of Birth*_____**
Address _____ ***Male*** _____ ***Female***_____
_____ ***Phone*** _____

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.**

(PRINT NAME OF STUDENT/FACULTY MEMBER)

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 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** _____
Student name

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PPD FORM 2020-2021

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***Address* _____ *Male* _____ *Female* _____**
_____ *Phone* _____

- ***ONE* OF THE FOLLOWING MUST BE COMPLETED WITHIN THE PAST 12 MONTHS.**

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

Date Implanted: _____ Read: _____ Result: _____

OR

2. **QuantiFERON TB Gold Result _____- Lab Sheet Must Be Attached**

3. **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

The Barbara H. Hagan School of Nursing & Health Sciences

FLU VACCINE FORM

PLEASE PRINT

Student Name ***Molloy ID Number***

E-Mail Address ***Phone Number*** ***Course & Section***

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***

Name of Provider ***License Number*** ***Stamp***

Address of Provider

DUE OCTOBER 1st