

**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: \_\_\_\_\_

**Diphtheria/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 \_\_\_\_\_  
(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*

**MOLLOY COLLEGE**  
**THE BARBARA H. HAGAN SCHOOL OF NURSING & HEALTH SCIENCES**  
**PPD FORM 2020-2021**

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*Anticipated Class  
next semester:*  

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*Course      Section*

*Last Name* \_\_\_\_\_ *First Name* \_\_\_\_\_ *ID#* \_\_\_\_\_  
*Maiden Name* \_\_\_\_\_ *Date of Birth* \_\_\_\_\_  
*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:**

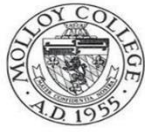
**Date:** \_\_\_\_\_ **Result:** \_\_\_\_\_

**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**

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*Student Name*

*Molloy ID Number*

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*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*

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*Name of Provider*

*License Number*

*Stamp*

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*Address of Provider*

***DUE OCTOBER 1st***