MOLLOY COLLEGE
The Barbara H. Hagan School of Nursing & Health Sciences

2021-2022 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 t*wo* PPDs implanted within 365 days of each other or a Quantiferon blood test.**
- **Each subsequent physical requires only o*ne* 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.**
AHA classes call Molloy Continuing Education at 516-323-3550 or 3559 (30 Hempstead Ave, Suite 254)
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 contact:

Krissy Hill (516) 323-3752

Jeanne Dazzo (516) 323-3666

Hagan Rm 205
9 am – 4:30 pm
Monday thru Friday

UNIFORM REQUIREMENTS

Lakeville Uniforms
271-11 Union Turnpike
New Hyde Park, NY 11040

Life Uniform
249 Old Country Road
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!!!*****

Updated Fall 2021

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***

***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.**

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(PRINT NAME OF STUDENT/FACULTY MEMBER)

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** _____
Student name

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

PPD 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***

*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. 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

MOLLOY COLLEGE
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Latex Allergy Policy

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 than1% 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

APPENDIX J

MOLLOY COLLEGE
THE BARBARA H. HAGAN SCHOOL OF NURSING & HEALTH SCIENCES
Health Insurance Portability and Accountability Acknowledgment Form

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 ____Broadlawn Manor Nursing & Rehab. Center ____Children & Family Services ____CNR Health Care ____Community Health Centers/Nassau Health Corp. ____Good Samaritan Hospital Medical Center ____Good Shepherd Hospice ____Holliswood Hospital ____Huntington Hospital ____Jamaica Hospital ____John T. Mather Memorial Hospital ____Komanoff Center for Rehabilitative Medicine ____Long Beach Hospital Home Care ____Long Beach Medical Center ____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	____North Shore/LIJ Health Care Systems ____North Shore University Hosp. at Manhasset ____North Shore University Hosp. at Glen Cove ____North Shore University Hosp. at Plainview ____North Shore University Hospital at Huntington ____North Shore University Hospital at Syosset ____Nursing Sisters Home Visiting Service ____Our Lady of Consolation Geriatric Care ____Pederson Kreg ____Peninsula Hospital Center ____St. Francis Hospital ____St. Johns Episcopal Hospital, South Shore ____St. Mary's Hospital for Children ____South Nassau Communities Hospital ____South Nassau Home Care ____South Oaks Hospital ____The Center for Developmental Disabilities	____Visiting Nurse Association of Long Island ____Visiting Nurse Service, Inc. ____Visiting Nurse Service of New York City ____Winthrop Home Care ____Winthrop Poison Control ____Winthrop University Hospital ____ Any other clinical agencies ____ _____ ____ _____ ____ _____ ____ _____

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 BY OCTOBER 1st

Fall 2021