Completed by student (PRINT CLEARLY) First Name _____ Middle Initial: ___ Last Name: _____ Student ID# _____

Program: Traditional Generic (B.S.) ☐ Accelerated Generic (B.S.) ☐ Master's/Post-Master's Certificate ☐ DNP ☐

## LEHMAN COLLEGE DEPARTMENT OF NURSING

# ANNUAL HEALTH CLEARANCE REQUIREMENTS


**Each Department of Nursing student must have current health clearance prior to each clinical nursing course:**

| | |
|---|---|
| **Undergraduate** (Generic/Accelerated, RN-BS) clinical courses: | **(NUR 301, 303, 304, 400, 405, 409).** |
| **Graduate** (Master's/Post-Master's Certificate, DNP) clinical courses: | **(NUR 770, 771, 772, 773, 774, 775, 776, 809, 810, 811).** |

Health clearance is required by the New York State Department of Health to determine that health care workers and students do not pose a health risk to clients, families, or co-workers and to assure that the student is physically able to fulfill the objectives of the educational program.

Attached is an examination form and list of laboratory tests which must be completed and signed by a licensed healthcare provider (physician, physician's assistant, or nurse practitioner) of your choice. The completed form, including the evaluation of lab results, must be uploaded to **DISA Health Care CB.**

Immunization documentation is required only once if immunity is confirmed. **Note:** The Department of Nursing (DON) requires a criminal background check and drug test for program admission, as these are mandatory for clinical placement at affiliated health institutions

**Health Clearance is valid for 12 (twelve) months**

**INSTRUCTIONS**

**Student: Fill in the upper top portion of each page of this document, complete pages 4, 5, 6, and 7 and sign where required.**

**Healthcare provider: Complete and sign pages 5, 6, 7, 8.**

**Submit this Health Clearance Form, any lab reports, a signed CPR card (both sides), and N-95 fit test; for RN-BS, Master's/Post-Master's, DNP students only also upload your Liability Certificate of Insurance to DISA Health Care CB by the following deadlines: Advanced standing DNP students must carry NP Insurance.**

- **Incoming Accelerated Generic students:** Submit all documentation by May 1st.
- **Incoming Traditional Generic students:** Submit all documentation by July 1st.
- **Continuing Traditional Generic students:** Submit all documentation by June 15th.
- **RN-BS students:** Submit all documentation as needed for clinical courses. Deadline dates will vary.
- **Master's/Post-Master's students:** Submit by deadlines below to facilitate early field placements. Submit all documentation, including a copy of your NYS Registered Nurse License and Registration to **DISA Health Care CB**.

Fall Request –Deadline May 15th
Spring Request –Deadline October 15th
Summer Request –Deadline March 15th

- Failure to submit your completed **Health Clearance Form and all required documents**, by the deadline will result in delay of clinical placement and progression in the program.
- Drug screening must be completed 30 days prior to each semester. For the Fall semesters, between the last week of July and the first week of August. For the Spring semesters, between the last week of December and the first week of January.
- For Accelerated students, drug screening must be completed between the last week of April and the first week in May for the Summer and Fall semesters. For the Spring semesters, between the last week of December and the first week of January.

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# DOCUMENT REQUIREMENTS FOR CLINICAL PLACEMENT AND PERFORMANCE
## Generic/Generic-Accelerated, RN-BS, Master's/Post-Master's Certificate

**IMPORTANT NOTE: All clinical sites require a drug test and background check.**

- This page will serve as a checklist to complete all required clinical documents. You are not required to upload **this page** to **DISA Health Care CB**.
- **Please note: Clinical site may ask for a copy of your clinical documents.** Carry a set of these documents with you to the clinical site to have available if requested for review/submission by the clinical site manager/coordinator, preceptor, or your clinical or lecture instructor.

| | | |
|---|---|---|
| **A.** | **Department of Nursing's Health Clearance Form - Valid for 12 months from date of exam.**<br>Submit completed, signed original Health Clearance to **DISA Health Care CB Portal** – **ALL NURSING STUDENTS** | *Check-Off Completed* |
| | **SUMMARY OF REQUIRED HEALTH CLEARANCE** | |
| | *1.* **Physical Examination annually.** | ☐ |
| | *2.* **Laboratory Tests** – Evaluation of test results as "Normal" or "Abnormal" must be done by the licensed Healthcare Provider. | ☐ |
| | • CBC with Differential | ☐ |
| | • Urinalysis with Microscopic exam | ☐ |
| | • Hepatitis B Surface Antibody Titer | ☐ |
| | • Varicella (Chicken Pox) – Positive Titer required. | ☐ |
| | • Measles, Mumps & Rubella – Positive Titer required. | |
| | *3.* **Immunizations** | |
| | • **Tetanus-Diphtheria-Pertussis (DPT)**– Within 10 years (give exact date) | ☐ |
| | • **TB Screening** – All students must have an annual QuantiFERON-TB Gold test.<br>• Students who have a positive QuantiFERON-TB Gold test must have a chest x-ray and provide evidence that they are being treated prophylactically, **as per New York State and CDC guidelines,** in order to continue in clinical.<br>  • A copy of the radiology report must be attached to the Health Clearance Form. | ☐ |
| | • **Vaccines:**<br>• **Influenza Vaccine**. Annual Influenza vaccine is required annually as soon as it becomes available for the current flu season (which covers the months of **August – May**).<br>• **Hepatitis B Vaccine**. It is strongly recommended that all students receive the Hepatitis B vaccine. If you decline this vaccine, then you must sign the Declination of Hepatitis B Vaccine (pg. 9).<br>• **COVID-19 Vaccine.** This vaccine series is required.<br>• **Booster vaccines are required for negative (non-immune) titers.** | ☐<br>☐ |
| | *4.* **Additional requirements:** | *Read & Understood* |
| | • Drug screening – 10 panel tests provided through **DISA Health Care CB Portal**.<br>• Background Check provided through **DISA Health Care CB Portal**.<br>• N-95 Fit testing provided by the Nursing Department. Details to follow. | ☐ |
| **B.** | **Cardio-Pulmonary Resuscitation (CPR)** (also known as **Basic Cardiac Life Support (BLS/BCLS) for Healthcare Providers -** Source: **The American Heart Association** CPR classroom training – **valid for 2 years - ALL NURSING STUDENTS**.<br>• Upload a copy of the front and back of your signed CPR card to **DISA Health Care CB Portal**. | *Check-Off Completed*<br>☐ |

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| | | *Check-Off Completed* |
|---|---|---|
| **C.** | **Consent to Release Documents form – Upload signed Consent to Release form to** DISA Health Care CB Portal. | ☐ |
| **D.** | **Malpractice Liability Insurance - valid for 12 months – ALL RN-BS AND GRADUATE NURSING STUDENTS ONLY**<br>**(The following items, do not apply to Traditional Generic and Accelerated Generic students.)**<br><br>**Nurses Service Organization (NSO): 800-247-1500. Apply online at: http://www.nso.com/professional-liability-insurance. Upload a copy of your Certificate of Insurance to** DISA Health Care CB Portal. | ☐ |
| **E.** | **RN License and Registration – ALL RN-BS, MASTER'S/POST-MASTER'S STUDENTS ONLY**<br>**Upload a copy of your current New York State RN license and registration to** DISA Health Care CB Portal. | ☐ |
| **F.** | **Application for Clinical Placement – ALL MASTER'S/POST-MASTER'S STUDENTS ONLY**<br>**See Graduate Documents & Forms** | ☐ |

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**LEHMAN COLLEGE DEPARTMENT OF NURSING**

# ANNUAL HEALTH CLEARANCE RECORD

**(Expires 12 (twelve) months from date of your physical exam)**

**Name**_____ _____
Print First Middle Last DOB

**Street Address**_____

**City**_____ **State**_____ **Zip**_____ **Phone #**_____

**Lehman Email** _____

## Personal Health History: (To be completed by the student)

Have you ever had any of the following? (Circle **YES** and indicate date, or circle **NO**)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Back trouble | Yes | _____ | No | Joint Disease | Yes | _____ | No |
| Asthma | Yes | _____ | No | Allergy | Yes | _____ | No |
| Tuberculosis | Yes | _____ | No | Ear Disorders | Yes | _____ | No |
| Skin Disorders | Yes | _____ | No | Sexually Transmitted Infection (STI) | Yes | _____ | No |
| Kidney Disorders | Yes | _____ | No | Seizure Disorder | Yes | _____ | No |
| Ulcers | Yes | _____ | No | Mental/Emotional Disorders | Yes | _____ | No |
| Cancer | Yes | _____ | No | Hernia | Yes | _____ | No |
| Diabetes | Yes | _____ | No | Rheumatic Fever | Yes | _____ | No |
| Heart Murmur | Yes | _____ | No | Pneumonia | Yes | _____ | No |
| High Blood Pressure | Yes | _____ | No | Low Blood Pressure | Yes | _____ | No |
| Cardiac Disease | Yes | _____ | No | Drug Allergies | Yes | _____ | No |

Describe any items checked YES above: _____

_____

_____

List previous serious illnesses/operations/hospitalizations: _____

_____

_____

**I understand that a drug test and criminal background check are required for participation in clinical rotations. If the site denies my placement based on the results and the Nursing Department is unable to place me at another site, then I may not be able to complete the clinical practicum requirements and will have to withdraw from the nursing program.**

**Student's Signature:** _____ **Today's Date:** _____

Completed by student (PRINT CLEARLY) First Name _____ Middle Initial: ____ Last Name: _____ Student ID# _____

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# ANNUAL TB SCREENING

1. Have you experienced any of the following symptoms in the past year? (Circle **YES** and indicate date, or circle **NO**)

| | | | |
|---|---|---|---|
| a.) A productive cough for more than 3 weeks? | **Yes** | **Date:** | **No** |
| b.) Hemoptysis (coughing up blood)? | **Yes** | **Date:** | **No** |
| c.) Unexplained weight loss? | **Yes** | **Date:** | **No** |
| d.) Fever, Chills, or night sweats for no known reason? | **Yes** | **Date:** | **No** |
| e.) Persistent shortness of breath? | **Yes** | **Date:** | **No** |
| f.) Unexplained fatigue? | **Yes** | **Date:** | **No** |
| g.) Chest Pain? | **Yes** | **Date:** | **No** |

2. Have you had contact with anyone with active tuberculosis disease in the past year? **Yes** **No**

3. Do you have a medical condition, or are you taking medications which suppress your immune system? **Yes** **No**

**Student's Signature:** _____ **Today's Date:** _____

Completed by student (PRINT CLEARLY) First Name _____ Middle Initial: ___ Last Name: _____ Student ID# _____

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## LEHMAN COLLEGE DEPARTMENT OF NURSING

### Annual Physical Examination: (To be completed by a licensed Healthcare Provider)

**Student's Name:** _____ **Today's Date:** _____

Height:_____ Weight:_____ B.P:_____mmHg Pulse:_____ Temp:_____

Visual Acuity: O.D._____ Corrected:_____ O.S._____ Corrected:_____

| SYSTEM | Normal | Abnormal | REMARKS (Describe Abnormalities) |
|---|---|---|---|
| Skin | | | |
| Head & Neck | | | |
| Nose & Sinuses | | | |
| Mouth & Throat | | | |
| Gums & Teeth | | | |
| Eyes | | | |
| Ears, Hearing | | | |
| Thorax & Lungs | | | |
| Breast | | | |
| Heart & Vascular | | | |
| Lymphatics | | | |
| Abdomen | | | |
| Hernia | | | |
| Anus & Rectum | | | |
| Genito-Urinary | | | |
| Endocrine | | | |
| Musculoskeletal/Spine | | | |
| Neurologic | | | |
| Hematologic | | | |
| Mental/Emotional | | | |

Is there any emotional, mental, or physical condition for which this student is under medical supervision and/or taking medication? **Yes**_____ **No**_____

**Specify:**_____

_____

**Healthcare Provider Name**: _____ **License #** _____ **State:** _____

**Signature**: _____ **Exam Date**: _____

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**LEHMAN COLLEGE DEPARTMENT OF NURSING**

## Laboratory Test Results:

Urinalysis:_____ CBC:_____

QuantiFERON-TB Gold Test _____ Chest x-ray (if applicable): _____
Date/Result Date/Results: _____

TB Prophylaxis prescribed: Yes _____ No _____

***All students must have an annual QuantiFERON-TB Gold test.** Students who have a positive QuantiFERON-TB Gold Test must have a chest X-ray and provide evidence that they are being treated prophylactically, adhering to New York Department of Health protocol and CDC guidelines for appropriate treatment. A copy of the radiology report must be attached to the Health Clearance Form.

Recommendation for physical activities: Full activity_____ Limited activity_____
If limited activity, specify limitations: _____

I certify that _____has had the required immunizations and that the physical examination and laboratory test results are within normal limits.

**Healthcare Provider Name:** _____

**Healthcare Provider Signature:** _____

**Healthcare Provider License #** _____ **State:** _____

**Address:** _____

**Phone #:** _____

**Email:** _____

**Date of Exam:** _____

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**LEHMAN COLLEGE DEPARTMENT OF NURSING**
**IMMUNIZATION RECORD**
**(To be completed by a licensed Healthcare Provider)**

| | Vaccination Dates | Titer (Give exact numbers) | Date of Titer | Immune/Not Immune |
|---|---|---|---|---|
| **DPT** | | | | |
| **Measles** | | | | |
| **Mumps** | | | | |
| **Rubella** | | | | |
| **Varicella** | | | | |
| **Hepatitis B (HBV)** | | | | |

**Hepatitis B (HBV)**

| Vaccination 1 Date | Vaccination 2 Date | Vaccination 3 Date |
|---|---|---|
| | | |

**Influenza Virus Vaccine: Upload a copy of your Vaccination Printout**

| | Dose | Manufacturer | Lot Number | Expiration Date | Sticker Number | Provider Name/Location |
|---|---|---|---|---|---|---|
| | | | | | | |

**Vaccine Administrator:** _____ **Title:** _____ **Signature:** _____

**COVID-19 Vaccinations: Upload a copy of COVID-19 vaccination card**

| Date | Dose | Manufacturer | Lot Number | Expiration Date | Sticker Number |
|---|---|---|---|---|---|
| | | | | | |

**Titers are required for Mumps, Measles, Rubella, Varicella (Chicken Pox), and Hepatitis B. If titers do not show immunity, the appropriate vaccinations are required.**

**Healthcare Provider Name:**_____

**License #:**_____

**State:**_____

**Healthcare Provider Signature:**_____

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**LEHMAN COLLEGE**
**THE CITY UNIVERSITY OF NEW YORK**
**DEPARTMENT OF NURSING**

## DECLINATION OF HEPATITIS B VACCINE*

I understand that, due to my occupational exposure to blood or other potentially infectious materials as a nursing student assigned to care for clients in the clinical setting, I may be at risk for acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine.

Although my Hepatitis antigen/antibody titer shows that I am not immune to Hepatitis B Virus, I decline Hepatitis B vaccination at this time. I understand that, by declining this vaccine, I could be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I understand that I can receive the vaccination series.

_____

**Student Print Last Name** **First Name**

_____ _____

**Signature of Student** **Date**

*** Prior to signing this declination form, it is recommended that you discuss your decision with your primary care provider.**