BRONX COMMUNITY COLLEGE CUNY
of The City University of New York
Department of Nursing & Allied Health Sciences

GUIDELINES FOR HEALTH CLEARANCE

1. All sections of the medical form **must** be completed by your Healthcare Provider with a numerical value for all titers and a copy of the Labs. If titers are low, your Healthcare Provider should administer the vaccines.

2. Health clearance cards are only good for one semester. A new health clearance **must** be obtained each semester.

3. If you have a history of a (+) PPD, a hard copy of your Chest X-ray results is required with your medical form.

4. Health clearance cards cannot be obtained during the registration period. Please adhere to the posted schedule in Blackboard.

5. Students are responsible for making their own copies of the medical form. Copies should be made before it is submitted to the school nurse. Make three (3) copies in advance of going to submit your form.

6. Health requirements should be taken care of in a timely fashion prior to the beginning of each semester. (A health clearance card will be provided)

7. **No student** will be admitted to the clinical area without a health clearance card.

8. It is your responsibility to review the completed form while you are with your Health Care Provider. Incomplete forms will not be accepted.

[NOTE] In addition to the health requirements indicated on the physical examination form, affiliating clinical agencies may require additional screening such as substance abuse and past criminal conduct.

You must comply with all clinical screening requirements. Failure to do so or a positive finding will result in immediate dismissal from the clinical agency. If you are dismissed from a clinical agency, there will be **no** alternative clinical placement available.

Of THE CITY UNIVERSITY OF NEW YORK
HEALTH SERVICES

Ph: 718.289.5858 *OFFICE*
Fax: 718. 289.6074

MEDICAL RECORD FOR NURSING STUDENTS

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____ TELEPHONE: _____

In addition to a yearly physical examination, the following immunizations are required of all Nursing Students:

LABWORK	DATE	RESULT
Hepatitis B Titer*	_____	_____
*(*Must Include Range value*)		Signature
Hepatitis B Immunization	1st _____	_____
	2nd _____	_____
	3rd _____	_____

(**Must Include Range value*)	Date of Titer	Result/Lab Values
Measles/Rubeola	_____	_____
Rubella	_____	_____
Mumps	_____	_____
Varicella	_____	1st dose _____ 2nd dose _____
Diphtheria- DPT (Every 7 Years)	Date: _____	
PPD	Date:_____	Result_____
Chest X-Ray (If PPD is Positive)	Date: _____	Result_____ (Attach documentation)
Influenza	Date: _____	

Physician's Signature: _____

ALL Medical information is confidential in compliance with HIPAA

PHYSICAL EXAMINATION FORM: (*to be completed by Physician*)

Height: ____/_____ Vision: O.D._____ O.S._____ Blood Pressure:_____ mmHG
Weight: _____ lbs.

LAB WORK: Hct: _____ Urinalysis: Glucose_____ Protein: _____
Recommended for students over 40 years of age:
EKG: _____ Chemistry: _____ SIGNIFICANT MEDICAL HISTORY_____

FAMILY MEDICAL HISTORY_____

	NORMAL	ABNORMAL	COMMENTS
1. Head, Ear, Nose, Throat			
2. Respiratory			
3. Cardiovascular			
4. Gastrointestinal			
5. Hernia			
6. Eyes			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Allergies			

Depression screening: Yes_____ No_____ COMMENTS_____

Do you have any recommendation regarding the care of this student? Yes ___ No ___
If yes, describe briefly_____

Is the student now under treatment for any medical or emotional condition?
Yes___ No ___ If yes, describe briefly _____

Recommendation for *Health & Physical Education class*: Full Activity___ Modified Activity ____ No Activity___ Explain Restriction/Precautions_____

Recommendation to participate in *Competitive Athletics*: Full Activity___ Modified Activity ____ No Activity___ Explain Restriction/Precautions_____

Based on the Medical History and Physical Examination of this student, there is NO evidence of Health Impairment which is of Potential Risk to Patients or which interfere with this performance of his/her duties.

Physician's Signature_____
Address_____
Phone _____ **Date**_____

STAMP (Required)