

**LEHMAN COLLEGE  
DEPARTMENT OF NURSING**

**ANNUAL HEALTH CLEARANCE REQUIREMENTS**

**Each student in the Department of Nursing must have current health clearance prior to each clinical nursing course (NUR 301, 303, 304, 400, 405, 409). Health clearance is valid for twelve (12) months.**

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 physician or nurse practitioner of your choice. The completed form, including the evaluation of lab results, must be returned to the Department of Nursing.

Documentation of immunization/immunity to communicable disease needs to be completed only once if immunity is confirmed.



**Submit the original and two copies of the completed Health Clearance form, along with three copies of your Liability Insurance and CPR documentation to the Nursing Department by the following deadlines:**

- C Current nursing students - three weeks prior to the official first day of classes**
- C New nursing students - day of scheduled Nursing Orientation (noted in Nursing Packet)**

**☞ \*FAILURE TO RETURN A COMPLETED FORM WITH ALL REQUIRED DATA BY THE REQUIRED DATE WILL RESULT IN YOU BEING BARRED FROM CLINICAL WHICH WILL LEAD TO AN AUTOMATIC FAILURE.**

**☞ \*\*PLEASE MAKE A COPY OF YOUR COMPLETED HEALTH CLEARANCE FORM AND OTHER DOCUMENTATION FOR YOUR OWN RECORDS.**

**☞ COPIES WILL NOT BE MADE FOR YOU IN THE NURSING DEPARTMENT.**

**☞ ONCE SUBMITTED, FORMS WILL NOT BE RELEASED TO YOU TO MAKE COPIES.**

**RETURN FORMS TO: Department of Nursing  
T-3 Building, Room 201**

**LEHMAN COLLEGE  
DEPARTMENT OF NURSING**

**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 physician.

CBC with Differential

Urinalysis with Microscopic exam

Hepatitis B Antigen/Antibody Titre

Rubella Titre – **Positive** titre required (give exact numbers). Immunization required if titres are not immune.

Varicella (Chicken Pox) – **Positive** Titre required.

Measles, Mumps (if no documentation of immunizations available)

**3. Immunizations**

Tetanus-Diphtheria – Within 10 years (give exact date)

PPD – All students must have a PPD, including those who have previously received BCG. A chest x-ray is required at the time of conversion and every 5 years thereafter. A copy of the radiology report must be attached to the Health Clearance Form.

Students who convert to PPD positive must provide evidence that they are being treated prophylactically in order to continue in clinical. (Department of Health requirement)

**Students who are PPD negative must have a repeat PPD prior to each clinical semester.**

Mumps – Documentation of immunization or positive titre required.

Measles – Documentation of immunization or positive titre required.

**4. Additional requirements may be imposed by specific agencies with which the Department of Nursing affiliates.** These include, but are not limited to, drug and alcohol screening, background investigation including criminal record name search, and Child Abuse and Maltreatment inquiry.

**To be completed by Nursing Department**

Semester 1: \_\_\_\_\_ Clinical Section/Instructor: \_\_\_\_\_ Clinical Site: \_\_\_\_\_  
Semester 2: \_\_\_\_\_ Clinical Section/Instructor: \_\_\_\_\_ Clinical Site: \_\_\_\_\_

**LEHMAN COLLEGE  
DEPARTMENT OF NURSING**

**ANNUAL HEALTH CLEARANCE RECORD**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
Last First Middle

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

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

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

Back trouble. . . . .	Yes _____	No _____	Rheumatism. . . . .	Yes _____	No _____
Asthma. . . . .	Yes _____	No _____	Allergy. . . . .	Yes _____	No _____
Tuberculosis. . . . .	Yes _____	No _____	Ear Problems . . . . .	Yes _____	No _____
Skin Problems. . . . .	Yes _____	No _____	Gonorrhea or Syphilis. . . . .	Yes _____	No _____
Kidney Problems. . . . .	Yes _____	No _____	Seizure Disorder. . . . .	Yes _____	No _____
Ulcers. . . . .	Yes _____	No _____	Mental/Emotional Prob. . . . .	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 _____

Describe any items checked YES above: \_\_\_\_\_

List previous serious illnesses/operations: \_\_\_\_\_

Student's Signature: \_\_\_\_\_ 4-digit I.D.#: \_\_\_\_\_

Date: \_\_\_\_\_

**To be completed by Nursing Department**

Semester 1: \_\_\_\_\_ Clinical Section/Instructor: \_\_\_\_\_ Clinical Site: \_\_\_\_\_

Semester 2: \_\_\_\_\_ Clinical Section/Instructor: \_\_\_\_\_ Clinical Site: \_\_\_\_\_

**LEHMAN COLLEGE DEPARTMENT OF NURSING**

**Annual Physical Examination: (To be completed by physician)**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ B.P.: \_\_\_\_\_ mmHg Pulse: \_\_\_\_\_ Temp.: \_\_\_\_\_

Visual Acuity: O.D. \_\_\_\_\_ Corrected: \_\_\_\_\_ O.S. \_\_\_\_\_ Corrected: \_\_\_\_\_

<b>SYSTEM</b>	<b>Normal</b>	<b>Abnormal</b>	<b>REMARKS (Describe Abnormalities)</b>
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			
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: \_\_\_\_\_

**Student's Name** (print): \_\_\_\_\_

**4-digit I.D.#:** \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_

**Exam Date:** \_\_\_\_\_

**To be completed by Nursing Department**

Semester 1: \_\_\_\_\_ Clinical Section/Instructor: \_\_\_\_\_ Clinical Site: \_\_\_\_\_  
Semester 2: \_\_\_\_\_ Clinical Section/Instructor: \_\_\_\_\_ Clinical Site: \_\_\_\_\_

**LEHMAN COLLEGE  
DEPARTMENT OF NURSING**

**Laboratory Test Results:**

Urinalysis: \_\_\_\_\_ CBC: \_\_\_\_\_

PPD : Negative \_\_\_\_\_ Positive \_\_\_\_\_ Chest x-ray : \_\_\_\_\_  
Date Date Date/Result

Prophylaxis prescribed: Yes \_\_\_\_\_ No \_\_\_\_\_

\*All students must have a PPD, including those who have previously received BCG. A chest X-ray is required at the time of conversion and every 5 years thereafter. A copy of the radiology report must be attached to the Health Clearance Form. Students who convert to PPD positive must provide evidence that they are being treated prophylactically in order to continue in clinical. (Department of Health requirement)

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.

Physician Name: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_

Date of Exam: \_\_\_\_\_

**Student's Name (print):** \_\_\_\_\_ **4-digit I.D.#:** \_\_\_\_\_

**To be completed by Nursing Department**

Semester 1: \_\_\_\_\_ Clinical Section/Instructor: \_\_\_\_\_ Clinical Site: \_\_\_\_\_

Semester 2: \_\_\_\_\_ Clinical Section/Instructor: \_\_\_\_\_ Clinical Site: \_\_\_\_\_

**LEHMAN COLLEGE  
DEPARTMENT OF NURSING**

**IMMUNIZATION RECORD  
(To be completed by a licensed physician)**

	<b>Vaccination Dates</b>	<b>Titre (Give exact numbers)</b>	<b>Date of Titre</b>	<b>Immune/ Not Immune</b>
<b>Tetanus-Diphtheria</b>				
<b>Measles</b>				
<b>Mumps</b>				
<b>Rubella</b>				
<b>Varicella</b>				
<b>Hepatitis B* (HBV)</b>				

Rubella titre is required. This test will tell you if you have ever been exposed to Rubella or German Measles and have developed antibodies. Rubella usually results in a mild illness unless you are pregnant. Rubella during the first three months of pregnancy can result in congenital defects in the infant. If your Rubella titre is negative or less than 1:8, it means you have not developed antibodies to Rubella. A vaccine which is available through your physician will immunize you against Rubella. If your Rubella titre is positive, you do not need any additional immunization.

Titres are required for Mumps, Measles, and Varicella (Chicken Pox) unless proof of vaccination is available. If titres do not show immunity, the appropriate vaccinations are required.

A Hepatitis antigen and antibody titre is required and should be done yearly. It is strongly recommended that all students receive the Hepatitis B vaccine if they are not immune. If your titres indicate that you are not immune and you decline to be vaccinated, you must sign a declination statement which is available from the secretary in the Department of Nursing.

**Student's Name (print):** \_\_\_\_\_

**4-digit I.D.#:** \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_

**Exam Date:** \_\_\_\_\_

**To be completed by Nursing Department**

Semester 1: \_\_\_\_\_ Clinical Section/Instructor: \_\_\_\_\_ Clinical Site: \_\_\_\_\_  
Semester 2: \_\_\_\_\_ Clinical Section/Instructor: \_\_\_\_\_ Clinical Site: \_\_\_\_\_

**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 titre 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.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

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