HUNTER BUSINESS SCHOOL
BUSINESS • HEALTHCARE • TECHNOLOGY

Clinical Documentation Requirements for the Practical Nursing & Radiologic Technology Programs

The attached documents are required to attend clinical hours at any participating clinical facility. These health forms must be completed and handed in to the respective program chairperson prior to your orientation day on_____.

Program Chairperson Name:_____Email: _____

Clinical Documentation Checklist:

1. **Physical examination**: Attached physical examination forms must be completely filled out, stamped with an office seal, and dated within the last 12 months by your health care provider and **must** include the following:

   QuantiFERON-TB Test: Blood work must be documented with lab results attached.

   - **Immunization record:** The following immunization records must be included: Tdap, MMR (2), Hepatitis B (3), Varicella (2).
   - **Laboratory titers report:** Lab sheets must be included for the following: Rubella, Rubeola, Mumps, and Varicella. Titers numerical values are required, Titers should be drawn no more than 90 days before your first day of class, which is on the following date:_____.
     *Please note: all lab results must show your NAME & D/O/B
   - **Flu Vaccine:** Is required for each flu season. The program will advise the start of the flu season according to the state Department of Health guidelines.
     *Please note: It may be required to receive the flu vaccine more than once during the course of the program.
   - **COVID-19 vaccination:** Hunter Business School will now require all newly enrolling students to be vaccinated. (According to the CDC, a person is considered fully vaccinated two weeks after receiving the second dose of a two-step vaccine (i.e. Pfizer & Moderna) or one dose of a one-step vaccine (i.e. Johnson & Johnson). Students must provide proof of vaccination to the Program Chairperson prior to the following date: _____.

2. **CPR certification:** Must through the American Heart Association (BLS for HealthCare Providers). This must be completed prior orientation. Certification cards must be submitted with this form.

3. **Criminal background check & drug screening:** All students are required to complete a 10-Panel urine drug screen and criminal background check through CastleBranch prior to orientation. See Admissions for details.

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To be filled out by student

Personal information:

Last Name:_____ First Name:_____ Date of Birth:___/___/_____

Address:_____

City:_____ State:_____ Zip Code: _____

Phone:_____ Email: _____

Emergency Contact:

Last Name:_____ First Name:_____ Relationship:_____

Address:_____

City:_____ State:_____ Zip Code: _____

Phone:_____ Email: _____

Have you had any of the following problems?

	Yes	No		Yes	No
Asthma			**Chronic Pain**		
Back Injury			**Skin Disease**		
Diabetes			**Jaundice**		
Epilepsy			**Tuberculosis**		
Fainting			**Surgeries**		
Head Injury			**Fractures**		
Heart disease			**Hypertension**		
Mental Illness			**Stomach Illness**		
List Allergies					

I have read this form and declare that I have no injury, illness, or ailment other than as listed, that would prevent me from starting or continuing in the program of Practical Nursing or Radiologic Technology. Any falsification or misrepresentation will be sufficient grounds for dismissal from the program or participating clinical sites.

Student Signature:_____ **Date:** _____

I, the undersigned, authorize release of information from any health record to participating clinical sites as required by the program for clinical site placement.

Student Signature:_____ **Date:** _____

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Clinical Documentation Requirements for the Practical Nursing & Radiologic Technology Programs

To be filled out by your Health Care Provider

I certify that (Print name of student)_____is in good health as determined by a recent physical examination of sufficient scope to ensure that they are free from health impairments which may be of potential risk to patients or other personnel or which may interfere with performance of their duties. This includes habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs and substances which may alter the individual's behavior. This individual is able to participate in clinical learning experiences as a student

Height:_____**Weight:**_____**BP:**_____**Pulse:**_____**Vision:**_____**Hearing:**_____

Skin:_____**Cognitive:**_____**Eyes:**_____**Ears:**_____**Nose:**_____**Throat:**_____

Lungs:_____**CVS:**_____**MSK:**_____**Abdomen:**_____**Lower Ext.:** _____

Upper Ext.:_____**Other:** _____

Medication: _____

Allergies: _____

Medical history: _____

I have examined the patient carefully and found them in_____health.

Health Care Provider Information:

Print Name:_____Signature:_____

Address: _____

City:_____State:_____Zip Code: _____

Phone:_____License State & Number: _____

Date of Examination: _____

Office Seal

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TB Testing:

- **QuantiFERON- TB Gold** (Lab report **MUST** be attached)_____**(Date)**

Titers:

➡ Offical laboratory titer reports are required & must be submitted with this form. ⬅

Titers:	Value	Date	Result	Vaccine if required	
Rubeola					
Rubella					
Mumps					
Varicella					

Immunization:

- **Tdap Vaccine:**_____(Date) *Within the last 10 years required.
- **MMR Vaccine:** Date # 1_____Date # 2 _____
- **Varicella Vaccine:** Date # 1_____Date # 2 _____
- **Hepatitis B Vaccine:** Date # 1_____Date # 2_____Date # 3 _____
- **Flu vaccine:** Date (Current year):_____Manufacture:_____Lot #: _____
- **COVID-19 vaccine -** According to the CDC, a person is considered fully vaccinated two weeks after receiving the second dose of a two-step vaccine (i.e. Pfizer & Moderna) or one dose of a one-step vaccine (i.e. Johnson & Johnson).

COVID-19 Vaccine administered:_____Date # 1_____Date # 2 _____
COVID-19 Booster administered: _____Date _____
(N/A for one-step vaccine)

➡ **(Please affix a copy of the front and back of COVID-19 Vaccination card or Lab report of shot administered)** ⬅

Physician Signature: _____

Date:

Office Seal

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