

Clinical Documentation Requirements for the Practical Nursing Program

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.
Please Note: If the QuantiFERON-TB test have a positive result a chest X-ray must be done within the last 2 years and submitted along with the physical forms.
Physical and QuantiFERON-TB Test are a yearly requirement. Forms must be resubmitted to the program chairperson upon expiration of the previous document
 - **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 requires all newly enrolling students to be fully 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).
COVID-19 Booster vaccination: Booster vaccination is also required 2 months after your J & J Janssen shot or 5 months after the second dose of Pfizer & Moderna.

Students must provide proof of vaccination & Booster 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.



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. 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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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

Tuberculin Testing:

- **QuantiFERON-TB TB Gold** (Lab report **MUST** be attached) _____ (Date)
(If positive, chest X-Ray is required every two years.)

Titers:

➡ Official 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). The COVID-19 booster is required 2 months after your J & J Janssen shot or 5 months after the second dose of Pfizer & Moderna.

Manufacturer: _____ **Date # 1** _____ **Date # 2** _____ ***Booster 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



Hepatitis B Declination Statement:

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 Infection. I have been informed of the need to be vaccinated with the Hepatitis B vaccine. However, I decline Hepatitis B Vaccine at this time. I understand that by declining this vaccination, I continue to be at risk of acquiring Hepatitis B, A serious disease.

Student Name (Please Print):

Student Signature: _____ **Date:** _____