HEPATITIS B DECLINATION:

 Liver disease may be caused by Hepatitis B Virus (HBV), which affects the liver. It is a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine by my Primary Health Care Provider. However, I decline the Hepatitis B Vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. 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 can receive the vaccination series.

Student’s Name_____________________________ ______________________________

Date_____/_____/______

Student Signature ______________________________________________________

NOTE: If Measles, Mumps, Rubella or Varicella IGG Blood Test are Negative, you will need the Vaccine(s).

HEPATITIS B: STOP: Only use this section for the following reason:

If you have a negative HBsAG Blood Test result and a negative HBsAB Blood test result, you will need either the Hepatitis B Vaccine Series or you will need to read and sign the Hepatitis B Declination statement below.

HEPATITIS B VACCINE SERIES DATES:

#1._____/_____/______ #2_____/_____/______ #3_____/_____/_____

OR

HEPATITIS B VACCINE DECLINATION:

Read & Sign below only if you have a negative HBsAG and negative HBsAB and you are not receiving the vaccine! 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 (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine by my Primary Health Care Provider. However, I decline the Hepatitis B Vaccination at this time. I understand that by declining this vaccine, I continue to 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 can receive the vaccination series.

Date_____/_____/______

Student Signature ______________________________________________________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

In compliance with Section 405 of the Health Code of New York State

I, the undersigned do hereby authorize the College of New Rochelle to provide

ALL CLINICAL AGENCIES under present and future contract with the

College of New Rochelle, School of Nursing and Health Care Professions with the following information:

Copies of the records of my medical and physical exams, immunizations, lab tests, health history and drug testing.

I am over 18 years of age and agree with the terms of this authorization.

Date_____/_____/______

Student Signature ______________________________________________________
**MD or NP’s REPORT of PPD and PHYSICAL EXAMINATION**

### TUBERCULOSIS TEST: P.P.D.

<table>
<thead>
<tr>
<th>Date placed</th>
<th>Date read</th>
<th>Result mm</th>
<th>(induration size required)</th>
</tr>
</thead>
</table>

- **Negative P.P.D.**
- **Positive P.P.D.**

**Chest X-ray if P.P.D. Positive:**

- Date of Chest X-ray: ____/____/____
- Result of Chest X-ray: ___________

**Receiving Therapy:**

- Yes: __________
- No: __________
- Refused: __________

**Vision:**

- R 20/______
- L 20/_______
- Corrected Vision: R 20/_______
- L 20/_______

**Height:** __________

**Weight:** _______ lbs.

**BP:** _______/______

**Pulse:** _______

**Allergy to:**

- Latex: _______
- Penicillin: _______
- Other Medication (name): __________

**Immunization Dates:**

- MMR #1: ____/_____/____
- MMR #2: ____/_____/____
- Tdap: ____/_____/____
- Varivax #1: ____/_____/____
- Varivax #2: ____/_____/____

### SYSTEM

<table>
<thead>
<tr>
<th>NORMAL</th>
<th>DESCRIBE ABNORMALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEENT</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitourinary</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Metabolic / Endocrine</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological</td>
<td></td>
</tr>
</tbody>
</table>

**Current & Chronic Problems:**

___________________________________________________________

Is there loss or seriously impaired function of any organ? YES________ NO________

I (approve______) (do not approve______) this student for a full time program of Nursing Field Experience.

**PHYSICIAN or NP’s SIGNATURE:**

________________________________________________________________________________________________________

**PRINT PHYSICAN or NP’s NAME:**

________________________________________________________________________________________________________

**State / License #**

________________________________________________________________________________________________________

Date of Physical Exam: __________

**Address:**

________________________________________________________________________________________________________

Date Form Signed: __________

**Use Office Stamp:**

This Medical Form must be uploaded through the Immunitrax portal with all of the lab reports for medical clearance.

https://cnrnursing.medicatimmunitrax.com