RCC | Rockland Community College
STATE UNIVERSITY OF NEW YORK

Records & Registration

Health Records & Documents Required

O Occupational Therapy O Other _____

Name: _____
Last First Middle

Student ID # _____ Date of Birth: _____

Address: _____
Street Apt #

City: _____ State: _____ Zip: _____

Phone #: _____ Email: _____

Students enrolled in a program which involves direct patient contact are required by Rockland Community College to provide proof of the following:

1. Positive Rubella antibody titer.
2. Positive Rubeola (Measles) antibody titer.
3. Positive Mumps antibody titer.
4. Adult Diphtheria/ Pertussis/ Tetanus immunization within the last (10) ten years.
5. Varicella antibody titer.
6. Documentation of influenza vaccination, **to be repeated yearly** or signed Influenza Vaccine Declination statement.
7. Tuberculin (Mantoux) test, **to be repeated yearly**. Positive findings shall require Chest X-Ray with negative results and appropriate clinical follow-up.
8. Documentation of Polio, if available. **Immunizations are NOT required.**
9. A physical assessment within the past year, demonstrating good health and ability to participate in course related activities safely and without restriction. (In addition completion of the Annual Health Review form will be required for yearly updates.)
10. Signed Information Release Form.
11. Signed Occupational Safety and Health Administration Hepatitis statement.
12. All students entering Rockland Community College for the first time must submit the Meningitis Response Form available in the Records & Registration, Technology Center.

145 College Road, Suffern NY, 10901
P – 845 – 574 – 4030 F – 845 – 574 – 4499

ANTIBODY TITRES

RUBELLA Date:_____Level:_____Status:_____

RUBEOLA Date:_____Level:_____Status:_____

MUMPS Date:_____Level:_____Status:_____

VARICELLA Date:_____Level:_____Status:_____

VACCINATIONS

ADULT DIPHTHERIA / PERTUSSIS /TETANUS (within last 10 years) Date:_____

POLIO Date:_____Type:_____

TUBERCULIN (MANTOUX) TEST – Must be done yearly.

Date Placed:_____Date Read:_____Test Results:_____MM:_____

POSITIVE MANTOUX MUST BE FOLLOWED BY CHEST X-RAY. Follow-up Chest X-Ray or appropriate clinical follow-up is to be submitted every 2 years while enrolled in a Nursing or Allied Health Program. (X-Ray must be completed within 1 year for NUR 232 students.)

CHEST X-RAY Date:_____Date Read:_____Results:_____

MEDICAL HISTORY: (Include present and past conditions)

_____

_____

_____

_____

_____

_____

_____

_____

_____

CURRENT STATUS

			Right	Left
Height: _____	Lungs: _____	Hearing:		
Weight: _____	Heart: _____	Vision:		
B / P: _____	Other: _____			

BODY SYSTEMS: SIGNIFICANT FINDINGS:

CURRENT MEDICATIONS/TREATMENTS:

GENERAL IMPRESSION/ASSESSMENT:

HEALTHCARE PROVIDER RECOMMENDATION:

I have examined and determined that_____is free from any health impairment of potential risk to self, patients or staff which might interfere with the performance of his/her duties, including, but not limited to the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or "substances" which may alter behavior. He/she can engage without restriction in clinical activities that may include bathing, turning, lifting, positioning, transferring bed to chair/stretcher and back to bed of conscious and unconscious patients and assisting unsteady patients with ambulation.

Signature of Health Care Provider Date

Stamp of Health Care Provider

Name of Health Care Provider (please print): _____

Phone Number: _____

Address: _____

INFORMATION RELEASE FORM

Name: _____
Last First Middle

Student ID #: _____

I, _____, hereby authorize Rockland Community College to release the enclosed health history, physical assessment information to any clinical practicum site to which I am assigned while I am a student in the Nursing or Allied Health Program.

I understand that I may revoke this authorization at any time and that this information will not be released to any other parties without my written consent.

_____
Signature Date

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION HEPATITIS STATEMENT

To participate in a clinical rotation, Nursing and Allied Health students must either be vaccinated or sign the waiver to comply with O.S.H.A. regulations and Public Health Law.

Place a check mark next to the statement which applies to you and sign your name on the line provided.

_____I have been vaccinated against Hepatitis B as shown below:

Date 1: _____ Date 2: _____ Date 3: _____

_____ I understand that due to potential exposure to blood or other potentially infectious materials during clinical/laboratory experiences, I may be at risk of acquiring Hepatitis B (HBV). However, at this time, I choose/have chosen not to receive the Hepatitis B series of vaccinations.

_____
Signature Date

☆ Hepatitis B Vaccinations and conformity with O.S.H.A. Blood Borne Pathogen Regulations are not Rockland Community College and State University of New York mandates. However, in order to participate in clinical rotation, affiliated health agencies may require students to either be vaccinated or sign the appropriate waiver to comply with O.S.H.A. regulations and Public Health Law.

*INFLUENZA VACCINE DECLINATION STATEMENT

I am aware that influenza is a serious respiratory disease and that the Centers for Disease Control strongly recommends that all healthcare workers receive an annual vaccination to prevent the disease and its complications. I am aware that clinical facilities may not allow me on patient units or may require that I wear a mask during patient contact if I am not vaccinated.

_____
Signature Date