How to Obtain Clinical Clearance for the Health Professions Program

2021 SUNY Orange Wellness Center

SUNY ORANGE
WELLNESS CENTER
Mind ~ Body ~ Spirit

Welcome to the SUNY Orange Nursing Program!

In this presentation, you will learn how to successfully complete the process to receive clinical clearance.

About the Wellness Center

- The Wellness Center processes and maintains all medical records and clinical clearances for nursing and other health professions students.
- Your health information is protected under federal law and will not be shared with anyone unless it is absolutely necessary.
- Our address: Wellness Center, SUNY Orange, 115 South Street, Middletown, NY 10940
- Our office is closed due to the COVID-19 pandemic.
- For questions or concerns, call (845) 341-4870 and leave a voice message, or email: wellnesscenter@sunyorange.edu. A nurse will return your query within 24-72 business hours.

Why do you need a clinical clearance?

- New York State Health Laws require all healthcare professionals and students enrolled in health professions programs to meet specific standards of health and fitness, and immunity to several communicable diseases.
- These requirements are more stringent than those affecting general college admission.
- All students enrolled in a SUNY Orange Health Professions program must receive a clinical clearance in order to attend classes and clinical.
- The clearance is good for one year.
- Second year students must be re-issued a new clearance, which requires repeating this process.

First Steps

- At this point, the Urine Drug Screen and Background Check should have already been completed through castlebranch.com.
  - If you have not done this yet do so IMMEDIATELY.
  - Failure to comply could result in the loss of your seat in the program.
- The Wellness Center has access to this information so there is no need to provide copies of your test results.

Important Dates

- Your clinical clearance must cover you for the entirety of your academic year.
- Therefore, the date of your physical and most recent tuberculosis test may not be prior to December 15, 2020.
- Physicals and tuberculosis tests completed before these dates will NOT be accepted.
- The physical and its accompanying documentation are due January 15, 2021.
- Physicals received after this date are subject to a $25 late fee.

The Official College Physical Form

- We consider completion of the physical form your first test as a health professions student.
- We understand that many of our students may not have completed such an extensive form before and it can be intimidating and confusing.
- We have done our best to simplify the form, but sometimes students have questions.
- Do not hesitate to call or email us with your questions.
  - Phone: (845) 341-4870. Leave a voice mail.
  - Email: wellnesscenter@sunyorange.edu
- A nurse will respond to your query in 24-72 business hours.

The Official College Physical Form

- The Wellness Center only accepts physicals submitted on the Official College Physical Form.
- Photocopies, faxes, or emailed forms are NOT accepted.
- ALL sections of the form must be addressed and completed.
- Make sure your name is clearly written at the top of each page.
- Use black ink only.

The Official College Physical Form

- You may choose your own healthcare provider to complete your form.
- This may be a medical doctor, doctor of osteopathy, nurse practitioner, or physician's assistant.
- If you do not have a healthcare provider or health insurance, your packet includes a list of practitioners who offer our students a discount.

Orange County Community College
HEALTH PROFESSIONS STUDENT
Physical Examination for Clinical Participation

Please return completed form to: SUNY Orange Wellness Center, 115 South Street, Middletown, NY 10940

NOTE: ONLY THIS PHYSICAL EXAMINATION FORM WILL BE ACCEPTED. USE BLACK INK ONLY.

SECTION I: Student Information

Program_____ Semester in Program (Circle one) 1 2 3 4 A#_____

_____ _____ _____ _____/____/____

Last Name First Name Middle Initial Date of Birth (MM/DD/YYYY)

_____ _____ _____ _____

Street Address City State Zip

_____ _____

Home Phone Number / Cell Phone Number E-Mail Address

_____ _____

Name and Relationship of Person to be Notified in Case of Emergency Best Phone Number

_____ _____ _____

Personal Physician Address Phone Number

SECTION II: Personal Health History – to be completed by the student. Please check **"YES"** or **"NO"** if you have or ever had any of the following conditions. You must address each box. DO NOT draw a line down the columns. If you answer "YES" to any condition explain your answer on page 2. **Specify the condition and give details.**

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
Pulmonary:			**Gastrointestinal:**			**Mental Health:**		
Chronic Cough			Ulcers			Anxiety/Panic		
Asthma			Ulcerative Colitis			Depression		
Hay Fever			IBS			Eating Disorder		
Cardiovascular:			Hernia			**Genitourinary**		
Heart Murmur			Gastric Reflux			**Pregnancy:**		
High Blood Pressure			**Endocrine:**			Due Date:		
Neurologic:			Diabetes			**Surgeries**		
Seizures			Thyroid Problems			**Hospitalizations**		
Dizziness/Fainting			**Cancer**			**Injuries**		
Migraines/Headaches			Immune Suppressed			**Daily Medications**		
Visual Disturbances			**Immune Disorder**			**Allergies:** (complete forms)		
Hearing Impairment			**Blood:**			Food/Drug/etc.		
Speech Deficit			Anemia			Latex		
Urine Drug Screen:			**Kidney Disorder**			**Other Conditions**		
Date:								

Orange County Community College does not discriminate on the basis of race, color, national origin, religion, creed, age, disability, sex, gender identification, sexual orientation, familial status, pregnancy, predisposing genetic characteristics, military status, veteran status, domestic violence victim status, criminal conviction or any other category protected by law. The College adheres to all federal and state civil rights laws prohibiting discrimination in public institutions of higher education.

Page One

- **Section I: Student information**
  - **Be sure to include your Program.**
  - **Be sure to include which semester you're enrolled in.**
    - If you are starting your program, you're in semester 1.

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Physical Examination for Clinical Participation

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SECTION I: Student Information

Program_____ Semester in Program (Circle one) 1 2 3 4 A# _____

_____ / / _____

Last Name First Name Middle Initial Date of Birth (MM/DD/YYYY)

_____

Street Address City State Zip

_____

Home Phone Number / Cell Phone Number E-Mail Address

_____

Name and Relationship of Person to be Notified in Case of Emergency Best Phone Number

_____

Personal Physician Address Phone Number

SECTION II: Personal Health History – to be completed by the student. Please check **"YES"** or **"NO"** if you have or ever had any of the following conditions. You must address each box. DO NOT draw a line down the columns. If you answer "YES" to any condition explain your answer on page 2. **Specify the condition and give details.**

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Asthma			Ulcerative Colitis			Depression		
Hay Fever			IBS			Eating Disorder		
Cardiovascular:			Hernia			**Genitourinary**		
Heart Murmur			Gastric Reflux			**Pregnancy:**		
High Blood Pressure			**Endocrine:**			Due Date:		
Neurologic:			Diabetes			**Surgeries**		
Seizures			Thyroid Problems			**Hospitalizations**		
Dizziness/Fainting			**Cancer**			**Injuries**		
Migraines/Headaches			Immune Suppressed			**Daily Medications**		
Visual Disturbances			**Immune Disorder**			**Allergies:** (complete forms)		
Hearing Impairment			**Blood:**			Food/Drug/etc.		
Speech Deficit			Anemia			Latex		
Urine Drug Screen:			**Kidney Disorder**			**Other Conditions**		
Date:								

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Page One

- **Be sure to include your email address and cell phone number.**
- **Be sure to include the name and best phone number of an emergency contact.**

Page One

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_____ _____ _____ ___/___/___

Last Name First Name Middle Initial Date of Birth (MM/DD/YYYY)

_____ _____ _____ _____

Street Address City State Zip

_____ _____

Home Phone Number / Cell Phone Number E-Mail Address

_____ _____

Name and Relationship of Person to be Notified in Case of Emergency Best Phone Number

_____ _____ _____

Personal Physician Address Phone Number

SECTION II: Personal Health History – to be completed by the student. Please check **"YES"** or **"NO"** if you have or ever had any of the following conditions. You must address each box. DO NOT draw a line down the columns. If you answer "YES" to any condition explain your answer on page 2. **Specify the condition and give details.**

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
Pulmonary:			**Gastrointestinal:**			**Mental Health:**		
Chronic Cough			Ulcers			Anxiety/Panic		
Asthma			Ulcerative Colitis			Depression		
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Cardiovascular:			Hernia			**Genitourinary**		
Heart Murmur			Gastric Reflux			**Pregnancy:**		
High Blood Pressure			**Endocrine:**			Due Date:		
Neurologic:			Diabetes			**Surgeries**		
Seizures			Thyroid Problems			**Hospitalizations**		
Dizziness/Fainting			**Cancer**			**Injuries**		
Migraines/Headaches			Immune Suppressed			**Daily Medications**		
Visual Disturbances			**Immune Disorder**			**Allergies:** (complete forms)		
Hearing Impairment			**Blood:**			Food/Drug/etc.		
Speech Deficit			Anemia			Latex		
Urine Drug Screen:			**Kidney Disorder**			**Other Conditions**		
Date:								

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- **Section II: Personal Health Information**
  - **Review all potential health conditions and answer "yes" or "no."**
  - **Do not draw a line down either column.**
  - **If you answer "yes" to any of these concerns you must explain why at the top of page 2.**

NAME:_____ PAGE 2

PERSONAL HEALTH HISTORY CONTINUED: Use the space below to explain any items answered YES on page 1. List all medications you take regularly, indicate any acute or chronic medical conditions, allergies to medications, food, latex, or other substances, and past history of surgical/medical illness. If you are currently under a doctor's care, give reason and name of provider.

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand that the information contained herein is for the purpose of determining my eligibility to participate in the clinical practice portion of my Health Professions program. I give permission for release of this information to Orange County Community College Wellness Center and authorize Orange County Community College Wellness Center to release this information to my Department chair, and to the clinical sites where I am assigned, if needed. I certify that the information contained herein is true and correct to the best of my knowledge.

STUDENT SIGNATURE: _____
(Parent signature if student is under 18)

SECTION III: TUBERCULOSIS SCREENING *Annual Tuberculosis screening is* ***required****.* ***FIRST YEAR*** *students may obtain a QuantiFERON-TB Gold blood test (QFT-G) or* ***TWO consecutive PPD's*** *done at least one week apart. The student may also provide proof of a negative PPD in the past 12 months,* ***and*** *ONE new PPD valid for one year.* ***SECOND YEAR*** *students may obtain a Quantiferon test or* ***ONE*** *PPD. NOTE: If QuantiFERON test was done the first year, the student needs another Quantiferon-TB test or 2 PPD's. If PPD or QuantiFERON test is positive see instructions below. If there is a* ***history of a positive PPD*** *the Clinical Evaluation (below) must be completed.*

PPD 1		**PPD 2** *Second PPD should be done no sooner than one week after first.*	
Date Administered:	Site:	Date Administered:	Site:
Manufacturer:	Lot #	Manufacturer:	Lot #
Administered by:		Administered by:	
Date Interpreted (within 48-72 hours):		Date Interpreted (within 48-72 hours):	
Interpreted by:		Interpreted by:	
Induration: mm.	Interpretation:	Induration: mm.	Interpretation:

QuantiFERON-TB Gold Blood Test Result: _____ ***A COPY OF THE LAB REPORT MUST BE ATTACHED***

IF the PPD OR QUANTIFERON-TB GOLD BLOOD TEST IS POSITIVE: A negative chest x-ray is required, and a copy of the x-ray report *must* be attached to the physical. The healthcare provider *must* complete the Clinical Evaluation (below).

CXR Date: _____ **Result:** _____ **Chemoprophylaxis ordered? If "YES" describe:** _____

CLINICAL EVALUATION FOR THOSE WITH HISTORY OF POSITIVE PPD *or* POSITIVE TB SCREENING

Repeat chest x-rays are not required for those with a history of positive PPD **and** a recent negative chest x-ray on file. However, an **Annual Clinical Evaluation** by a healthcare provider for signs and symptoms of active TB is required. The provider must assess and counsel for the following signs and symptoms of active TB:

SIGNS/SYMPTOMS	YES	NO	SIGNS/SYMPTOMS	YES	NO
Persistent Cough			Anorexia		
Fever			Night Sweats		
Hemoptysis			Weight Loss		

I have performed the above evaluation and find no evidence of active Tuberculosis at this time. A negative chest x-ray is on file.

Signature of Healthcare Provider: _____ Date: _____

Page Two

- **Be sure to SIGN where indicated.**

Note: Your signature permits the Wellness Center to release information to your department chair and to clinical sites where you are assigned (i.e. dates for physical, drug screen, immunizations, and TB screening). Medical history is not disclosed.

NAME:_____ PAGE 2

PERSONAL HEALTH HISTORY CONTINUED: Use the space below to explain any items answered YES on page 1. List all medications you take regularly, indicate any acute or chronic medical conditions, allergies to medications, food, latex, or other substances, and past history of surgical/medical illness. If you are currently under a doctor's care, give reason and name of provider.

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STUDENT SIGNATURE: _____
(Parent signature if student is under 18)

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PPD 1 | **PPD 2** *Second PPD should be done no sooner than one week after first.*

Date Administered:	Site:	Date Administered:	Site:
Manufacturer:	Lot #	Manufacturer:	Lot #
Administered by:		Administered by:	
Date Interpreted (within 48-72 hours):		Date Interpreted (within 48-72 hours):	
Interpreted by:		Interpreted by:	
Induration: mm.	Interpretation:	Induration: mm.	Interpretation:

QuantiFERON-TB Gold Blood Test Result: _____ ***A COPY OF THE LAB REPORT MUST BE ATTACHED***

IF the PPD OR QUANTIFERON-TB GOLD BLOOD TEST IS POSITIVE: A negative chest x-ray is required, and a copy of the x-ray report *must* be attached to the physical. The healthcare provider *must* complete the Clinical Evaluation (below).

CXR Date: _____ **Result:** _____ **Chemoprophylaxis ordered? If "YES" describe:** _____

CLINICAL EVALUATION FOR THOSE WITH HISTORY OF POSITIVE PPD *or* POSITIVE TB SCREENING

Repeat chest x-rays are not required for those with a history of positive PPD **and** a recent negative chest x-ray on file. However, an **Annual Clinical Evaluation** by a healthcare provider for signs and symptoms of active TB is required. The provider must assess and counsel for the following signs and symptoms of active TB:

SIGNS/SYMPTOMS	YES	NO	SIGNS/SYMPTOMS	YES	NO
Persistent Cough			Anorexia		
Fever			Night Sweats		
Hemoptysis			Weight Loss		

I have performed the above evaluation and find no evidence of active Tuberculosis at this time. A negative chest x-ray is on file.

Signature of Healthcare Provider: _____ Date: _____

Page Two

- **Section III: Tuberculosis Screening**

All students must submit proof of tuberculosis screening.

You may obtain 2 PPDs a minimum of one week apart, or a Quantiferon TB Gold Test.

NAME:_____ **PAGE 2**

PERSONAL HEALTH HISTORY CONTINUED: Use the space below to explain any items answered YES on page 1. List all medications you take regularly, indicate any acute or chronic medical conditions, allergies to medications, food, latex, or other substances, and past history of surgical/medical illness. If you are currently under a doctor's care, give reason and name of provider.

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STUDENT SIGNATURE:_____
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PPD 1		**PPD 2** *Second PPD should be done no sooner than one week after first.*	
Date Administered:	Site:	Date Administered:	Site:
Manufacturer:	Lot #	Manufacturer:	Lot #
Administered by:		Administered by:	
Date Interpreted (within 48-72 hours):		Date Interpreted (within 48-72 hours):	
Interpreted by:		Interpreted by:	
Induration: mm.	Interpretation:	Induration: mm.	Interpretation:

QuantiFERON-TB Gold Blood Test Result: _____ ***A COPY OF THE LAB REPORT MUST BE ATTACHED***

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CXR Date: _____ **Result:** _____ **Chemoprophylaxis ordered? If "YES" describe:** _____

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SIGNS/SYMPTOMS	YES	NO	SIGNS/SYMPTOMS	YES	NO
Persistent Cough			Anorexia		
Fever			Night Sweats		
Hemoptysis			Weight Loss		

I have performed the above evaluation and find no evidence of active Tuberculosis at this time. A negative chest x-ray is on file.

Signature of Healthcare Provider: _____ Date: _____

Page Two

- **Note: If you have a Quantiferon TB Gold Test in year one, you will need to do the same test the following year or obtain 2 PPDs.**

If you have 2 PPDs in year one you only need one PPD (or a Quantiferon TB Gold Test) in year two.

Page Two

NAME:_____ **PAGE 2**

PERSONAL HEALTH HISTORY CONTINUED: Use the space below to explain any items answered YES on page 1. List all medications you take regularly, indicate any acute or chronic medical conditions, allergies to medications, food, latex, or other substances, and past history of surgical/medical illness. If you are currently under a doctor's care, give reason and name of provider.

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Interpreted by:		Interpreted by:	
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QuantiFERON-TB Gold Blood Test Result: _____ ***A COPY OF THE LAB REPORT MUST BE ATTACHED***

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Fever			Night Sweats		
Hemoptysis			Weight Loss		

I have performed the above evaluation and find no evidence of active Tuberculosis at this time. A negative chest x-ray is on file.

Signature of Healthcare Provider: _____ Date: _____

If your PPD or Quantiferon TB Gold test is POSITIVE or you have a HISTORY of a positive PPD:

- **Your healthcare provider must order a chest X-Ray and you must attach a copy of the X-Ray report to your physical.**
- **Your healthcare provider must complete the clinical evaluation on the bottom right of page 2.**
- **Be sure your healthcare provider signs and dates this section.**

NAME: _____ PAGE 3

SECTION IV: REQUIRED IMMUNIZATIONS and SEROLOGIES

This document must be signed by a licensed Health Care Practitioner. **Proof of immunity is required regardless of age and previous immunization history**. An attached signed/stamped immunization record from your practitioner is acceptable. *Pregnant women SHOULD NOT be immunized and must submit M.D. note indicating EDC (due date).*

REQUIRED IMMUNIZATIONS	DOSE #1	DOSE #2	TITERS Date + Results
MMR (Measles, Mumps, Rubella) 2 Doses required **ON** or **AFTER** 12 months of age. The second MMR must be given 28 days after the first vaccine. MMR requirement is only for those born on or after 01/01/57. After 01/01/68 – vaccines must be "LIVE."			ATTACH LAB REPORTS ↓
OR			
Measles (Rubeola) – *2 doses required*			**Date:**
			Result:
Mumps – *2 doses required*			**Date:**
			Result:
Rubella (German Measles) – *1 dose required*			**Date:**
			Result:
VARICELLA (Chickenpox) – *2 doses required*			**Date:**
			Result:

Tetanus (TDAP): Immunization Date: _____ *(recommended within past 10 years)*

Meningitis Response Form Completed _____ (upload via: *https://mackform.sunyorange.edu/view.php?id=476573*)

Hepatitis B Vaccine series is *strongly* recommended:

Hepatitis B Vaccine: Dose #1_____ Dose #2_____ Dose #3_____

Hepatitis B Antibody Titer: Date: _____ Results: _____

(**NOTE:** The CDC recommends healthcare workers have Hep B antibody titer 6-8 weeks after dose three.)

Students who DO NOT wish to receive the Hepatitis B vaccine are REQUIRED to sign the waiver below each year.

Hepatitis B Waiver: As a student in a Health Professions program, I am aware of my increased risk of exposure to blood and other potentially infectious materials. I understand that this may place me at increased risk of acquiring Hepatitis B, a vaccine preventable disease. Nonetheless, I decline to be vaccinated at this time. I understand that I may revoke this waiver and begin the vaccine series at any future date.

Student Signature:_____ **Date:**_____

Print name of healthcare provider completing this form: _____

Healthcare Provider's Signature: _____ **Date:** _____

Page Three

- **Required Immunizations:**
  - **All health professions students are required to submit proof of 2 MMRs (Measles, Mumps, Rubella) and 2 Varicella (Chickenpox) vaccines**
  - **OR proof of POSITIVE titers (a blood test.)**
    - » **If using titers, you must submit the lab report.**

Page Three

NAME: _____ PAGE 3

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OR			
Measles (Rubeola) – *2 doses required*			**Date:**
			Result:
Mumps – *2 doses required*			**Date:**
			Result:
Rubella (German Measles) – *1 dose required*			**Date:**
			Result:
VARICELLA (Chickenpox) – *2 doses required*			**Date:**
			Result:

Tetanus (TDAP): Immunization Date: _____ *(recommended within past 10 years)*

Meningitis Response Form Completed _____ (upload via: *https://mackform.sunyorange.edu/view.php?id=476573*)

Hepatitis B Vaccine series is *strongly* recommended:

Hepatitis B Vaccine: Dose #1_____ Dose #2_____ Dose #3_____

Hepatitis B Antibody Titer: Date: _____ Results: _____

(**NOTE:** The CDC recommends healthcare workers have Hep B antibody titer 6-8 weeks after dose three.)

Students who DO NOT wish to receive the Hepatitis B vaccine are REQUIRED to sign the waiver below each year.

Hepatitis B Waiver: As a student in a Health Professions program, I am aware of my increased risk of exposure to blood and other potentially infectious materials. I understand that this may place me at increased risk of acquiring Hepatitis B, a vaccine preventable disease. Nonetheless, I decline to be vaccinated at this time. I understand that I may revoke this waiver and begin the vaccine series at any future date.

Student Signature:_____ **Date:**_____

Print name of healthcare provider completing this form: _____

Healthcare Provider's Signature: _____ **Date:** _____

- It is recommended but not required that students receive the Hepatitis B series.
- Please submit proof of three vaccines or a positive titer.
- If you have not received this vaccine and do not intend to you must sign the Hepatitis B waiver at the bottom of page 3.
- Vaccines are available at the Orange County Department
  - $65 each, Goshen clinic only
  - You must schedule an appointment: (845) 360-6587

NAME: _____ PAGE 3

SECTION IV: REQUIRED IMMUNIZATIONS and SEROLOGIES

This document must be signed by a licensed Health Care Practitioner. **Proof of immunity is required regardless of age and previous immunization history**. An attached signed/stamped immunization record from your practitioner is acceptable. *Pregnant women SHOULD NOT be immunized and must submit M.D. note indicating EDC (due date).*

REQUIRED IMMUNIZATIONS	DOSE #1	DOSE #2	TITERS Date + Results
MMR (Measles, Mumps, Rubella) 2 Doses required **ON** or **AFTER** 12 months of age. The second MMR must be given 28 days after the first vaccine. MMR requirement is only for those born on or after 01/01/57. After 01/01/68 – vaccines must be "LIVE."			ATTACH LAB REPORTS
OR			
Measles (Rubeola) – *2 doses required*			**Date:**
			Result:
Mumps – *2 doses required*			**Date:**
			Result:
Rubella (German Measles) – *1 dose required*			**Date:**
			Result:
VARICELLA (Chickenpox) – *2 doses required*			**Date:**
			Result:

Tetanus (TDAP): Immunization Date: _____ *(recommended within past 10 years)*

Meningitis Response Form Completed _____ (upload via: *https://machform.sunyorange.edu/view.php?id=476573*)

Hepatitis B Vaccine series is *strongly* recommended:

Hepatitis B Vaccine: Dose #1_____ Dose #2_____ Dose #3_____

Hepatitis B Antibody Titer: Date: _____ Results: _____

(**NOTE:** The CDC recommends healthcare workers have Hep B antibody titer 6-8 weeks after dose three.)

Students who DO NOT wish to receive the Hepatitis B vaccine are REQUIRED to sign the waiver below each year.

Hepatitis B Waiver: As a student in a Health Professions program, I am aware of my increased risk of exposure to blood and other potentially infectious materials. I understand that this may place me at increased risk of acquiring Hepatitis B, a vaccine preventable disease. Nonetheless, I decline to be vaccinated at this time. I understand that I may revoke this waiver and begin the vaccine series at any future date.

Student Signature:_____ **Date:**_____

Print name of healthcare provider completing this form: _____

Healthcare Provider's Signature: _____ **Date:** _____

Page Three

- **Recommended immunizations**
  - **It is recommended but not required that students receive a TDAP vaccine within the last ten years.**
  - **Students are required to complete the Meningitis Response Form which is available on our website: https://sunyorange.edu/wellness/forms.html**

The Flu Vaccine

- Seasonal Flu Vaccine is strongly recommended as most clinical sites require it.
- The flu vaccine is the best way to prevent influenza.
- Upload documentation of a flu vaccine for the 2020-2021 flu season via our secure online portal:

https://machform.sunyorange.edu/view.php?id=512526

- Keep a copy of your flu vaccine for your own records and bring it to clinical in case you are asked to produce proof of vaccine.

NAME: _____ PAGE 3

SECTION IV: REQUIRED IMMUNIZATIONS and SEROLOGIES

This document must be signed by a licensed Health Care Practitioner. **Proof of immunity is required regardless of age and previous immunization history**. An attached signed/stamped immunization record from your practitioner is acceptable. *Pregnant women SHOULD NOT be immunized and must submit M.D. note indicating EDC (due date).*

REQUIRED IMMUNIZATIONS	DOSE #1	DOSE #2	TITERS Date + Results
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OR			
Measles (Rubeola) – *2 doses required*			**Date:**
			Result:
Mumps – *2 doses required*			**Date:**
			Result:
Rubella (German Measles) – *1 dose required*			**Date:**
			Result:
VARICELLA (Chickenpox) – *2 doses required*			**Date:**
			Result:

Tetanus (TDAP): Immunization Date: _____ *(recommended within past 10 years)*

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Student Signature:_____ **Date:**_____

Print name of healthcare provider completing this form: _____

Healthcare Provider's Signature: _____ **Date:** _____

Page Three

- **If your healthcare provider writes anywhere on this page, make sure he or she signs off and dates at the bottom.**

Page Four

LAST NAME: **FIRST NAME:** **GENDER:** **AGE:** **PAGE 4**

SECTION V: PHYSICAL EXAMINATION and CLINICAL CLEARANCE FOR HEALTH PROFESSIONS STUDENTS

NOTE: Both Page 3 and 4 of this form must be completed and signed by the examining healthcare provider (MD, NP, PA):

VISION, UNCORRECTED: Right 20/ Left 20/	HEIGHT: WEIGHT:
VISION, CORRECTED: Right 20/ Left 20/	OVERWEIGHT: UNDERWEIGHT:
CONTACT LENSES: YES NO	EATING DISORDER:
GROSS HEARING:	BLOOD PRESSURE: /. PULSE:

REVIEW OF SYSTEMS REQUIRED:

HEENT:	HEART:
SKIN:	LUNGS:
MOUTH/TEETH:	ABDOMEN/GI:
NEURO:	KIDNEYS/GU
MUSCULOSKELETAL:	ENDOCRINE:
MEDICAL HISTORY:	SURGICAL HISTORY:

REQUIRED EVALUATION FOR CLINICAL PARTICIPATION – To be completed by Healthcare Provider:

ANSWER ALL QUESTIONS	YES	NO
1. Does the student have loss or serious impairment of any paired organ?		
2. Does the student have any limitation in normal activity (i.e. ability to lift, walk, sit or stand for prolonged periods)? If **"YES"**, indicate the nature of the limitation and the estimated length of time it will exist.		
3. Does the student display any evidence of a mental health disorder? If yes, describe the nature of the disorder. Do you recommend further investigation or treatment?		
4. Did you perform a complete medical examination as indicated on the above named student and find to the best of your knowledge that he/she is free from any physical or mental impairment which would impose a potential risk to patients or might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or "substances" which may alter the individual's behavior? If **NO**, identify active problems which may interfere with the performance of student's duties in the healthcare professions program:		

SIGNATURE and STAMP OF EXAMINING PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT:

Signature_____

Address: _____

City, State, Zip: _____

Phone: _____

Date: _____

STAMP

FOR OFFICE USE ONLY:
Date Received: _____ Reviewer: _____ Date Entered: _____ Reviewer: _____

Section V: Physical Examination and Clinical Clearance

- Your healthcare provider completes this section.
- Be sure each area is addressed.
- Be sure each of the four questions in the center of the form are addressed.
- Be sure your provider signs, dates, and stamps the form.

Submitting your Physical Form

- When your physical form is complete, MAKE A COPY OF EACH DOCUMENT FOR YOUR OWN RECORDS.
- Put the original documents in an envelope.
- Make sure your mailing address is on the envelope.
- Make sure you affix sufficient postage to your envelope.
- MAIL the entire packet to:

Wellness Center
SUNY Orange
115 South Street
Middletown, NY 10940

Submitting your Physical Form

- **NOTE: The Wellness Center and the College are not responsible for documents lost or damaged in transit, thus having a copy is *imperative*.**
- **You do not want to be the student who's physical was destroyed or "lost in the mail" and there's no copy.**

Submitting your Physical Form

- **Do NOT wait until the deadline to submit your form in case there are discrepancies or errors which may delay your clinical clearance and interfere with starting the program or attending clinical.**
- **A $25 late fee will be imposed on any physicals submitted after the deadline: January 15, 2021.**
- **Call or email the Wellness Center IMMEDIATELY if you experience any difficulties or delays meeting your deadline or completing the form. A nurse will respond to your query within 24-72 hours.**

Submitting your Physical Form

- A Wellness Center Nurse will visit the mailroom on Mondays and Wednesdays to pick up and process the physicals.
- The nurse will send an email to your SUNY Orange email account when your physical is received.
- If there are discrepancies with your physical or accompanying paperwork you will be notified either by email or phone.
- The nurse may request a phone interview or a Zoom session to discuss any issues.
- If your physical is incomplete or unsigned the entire package will be mailed back to you.

Receiving Your Clinical Clearance

- **Once your physical form and other documents are received, reviewed, accepted, and documented in your Banner account the nurse will EMAIL your clinical clearance to your SUNY Orange email account. This may take 7-10 business days.**

- **We recommend you print a copy and carry it with you to class and clinical. Save the digital document in a safe place on your computer, phone, tablet, etc. You will need to produce this form throughout your academic year.**

Reasons Forms Are Rejected

- Student did not put their name and/or personal identifying information on page one.
- Student did not complete the Personal Health History on pages one and two.
- Student did not sign the form on page two.
- Student did not attach supporting documentation, i.e. lab reports or immunization records.
- Student was not reimmunized after negative titers.
- Lines on page four are left blank.
- The provider did not sign, date, or stamp on page four.

Latex and Other Allergies

- Students with a history of Latex Allergy or Sensitivity must complete the Latex Allergy Action Plan included in your packet.
- Your healthcare provider must complete and sign this form due to the latex-rich environment in the simulation lab.
- Students with food, drug, or environmental allergies must complete the Allergy Action Plan included in your packet.

Change in Health Status

- If for any reason you experience a change in health status during your program (i.e. illness, accident, pregnancy) you must be re-evaluated by your healthcare provider and the Wellness Center.
- Obtain a Change in Health Status Form from your program chair, Wellness Center, or on our website: https://sunyorange.edu/wellness/forms.html.
- See your healthcare provider ASAP.
- Failure to comply in a timely manner may result in lost class and/or clinical time.

Tips

- Schedule your physical immediately. Procrastinating may result in difficulty securing an appointment within the prescribed timeframe.
- You may get your first PPD at any time. The second one must be within the prescribed timeframe.
- Use the checklist provided to monitor your progress during this process. This helps ensure your form is completed as required prior to submission.

Tips

- Before you leave your healthcare provider's office make sure all areas of your physical form are properly addressed.
- Make copies of all records! You may need them during your program and after graduation.
- Call or email the Wellness Center if you encounter any issues ASAP! We want to help.
- Phone: (845) 341-4870. Leave a voice message.
- Email: wellnesscenter@sunyorange.edu
- A nurse will return your call or email within 24-72 business hours.