

How to Obtain Clinical Clearance for Health Professions Programs

2020 SUNY Orange Wellness Center





Welcome to the SUNY Orange Health Professions Programs!

In this presentation, you will learn how to successfully complete the process to receive your clinical clearance aka "The Golden Ticket."



About the Wellness Center

- The Wellness Center processes and maintains all medical records and clinical clearances for 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.
- Phone: (845) 341-4870. Leave a voice message.
- email: wellnesscenter@sunyorange.edu.
- A nurse will return your query within 24-72 business hours. Note: In June and July the College is closed on Fridays.



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 for the following year.



First Steps

- At this point, the Urine Drug Screen and Background Check should already be 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 us with 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 May 14th.
 - Exceptions:
 - PHYSICAL THERAPIST ASSISTANT students may not complete their physical forms and tuberculosis screening prior to June 11th.
 - RADIOLOGIC TECHNOLOGY students may not complete their physical forms and tuberculosis screening prior to July 31st.
- Physicals and tuberculosis tests completed before these dates will NOT be accepted.



Important Dates

Deadlines to submit physicals are as follows:

PROGRAM	NO SOONER THAN	NO LATER THAN
MEDICAL LABORATORY TECHNICIAN Incoming Second Years	May 14 th July 1 st	June 17th July 31st
PHLEBOTOMY	May 14th	June 17th
NURSING Semester 3&4 Semester 1&2	May 14th May 14th	June 24 th July 9th



Important Dates

Deadlines to submit physicals are as follows:

PROGRAM	NO SOONER THAN	NO LATER THAN
OCCUPATIONAL THERAPY ASSISTANT	May 14th	July 2nd
DENTAL HYGIENE Incoming Second Years	May 14 th July 31st	July 31 st August 15th
PHYSICAL THERAPIST ASSISTANT	June 11th	August 4th
RADIOLOGY TECHNOLOGY	July 31st	August 13th



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 or faxes 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: Orange County Community College
WELLINES CENTED. Shepard Student Center - 2" Floor
IIS South Street, Middletown, NY 10940
Planes (984) 244-670

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

Program		Semester	1 2 3 4 (Circle one)	A#		_
Last Name	First Name		Middle Initial		Date of birth (MM/DD/	/m)
Street Address		City		State	Zip	p code
Home Phone Number Cell Phone Number			E-Mail Addr	ess		_
Name, relationship of Person to be Notified in	Case of Emergency		Home or Cell Phone		Business Phone	_
Personal Physician	Ad	ddress			Phone	_

SECTION II: Personal Health History – to be completed by student	Please check "YES" or "NO" if you have or ever had any of the following:

Yes	No	
		1. Lung Disease
		2. Ekronic Cough
		3. Asthma
		4. Shortness of Breath
		S. Hay Fever
		6. Heart Disease
		7. Heart Murmur
		8. Rheumatic Fever
		9. Palpitations
		10. Chest Pains
		11. High Blood Pressure
		12. Neurologic Impairment
		13. Seizure Disorder
		14. Dizziness/Fainting
		15. Migraine Headaches
		16. Visual Disturbances
		17. Hearing Impairment

Yes	No		Ye	S	No	T
		18. Speeck Defect				Ī
	П	19. Kidney disease				Ī
	П	20. Intestinal Disease				Ī
	П	21. Ulcers				I
	П	22. Gastrio Reflux				I
		23. Herria				I
		24. Food/Drug Allergies				I
		25. Latex Allergy				I
		26. Endocrine Disorders				l
		27. Thyroid Problems				
		28. Diabetes	⊩	_	├	ł
		29. Immune Disorder	⊩	_	-	ł
		30. Skin Conditions	╙	_	_	ł
		31. Orthopedic Problems	⊩	_	\vdash	ł
		32. Back Problems	⊩	_	\vdash	ł
		33. Knee or Foot Problems	⊩	_	_	ł
		34. Mobility Impairment	╙		_	l

П	Yes	No	
П			36. Physical Disability
П			37. Cancer
			38. Immunity Suppressed
			39. Anemia
			40. Anxiety/Panic Disorder
П			41. Depression
П			42. Eating Disorder
П			43. Drug/Alcohol Dependency
П			44. Tobacco Usage
$\ $			45. Are you pregnant? EDC:
П			48. Surgeries
П			47. Hospitalizations
П			48. Injuries
П			49. Daily Medications
1[50. Other Medical Conditions
П			

Please comment on next page on all items checked "YES". Specify number and give details.

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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.





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

Please return completed form to: Orange County Community College WELLNESS (EMEER, Shepard Student Center – 2rd Floor IIS South Street, Middletown, NY 10940 Plone: (345) 341-4570

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

SECTION	N I- 5	udant	Information	

Last Name	First Name	Middle Initial	Date	of birth (MM/00/7Y)
Street Address		City	State	Zip code
Home Phone Number / Cell Ph	one Number	E-Mail Add	ress	
Name, relationship of Person to	be Natified in Case of Emergency	Home or Cell Phone	Busin	ess Phone
Personal Physician	Addre	ESS	Phone	

SECTION II:	Personal	Health	History -	- to be	compli	eted b	y stud	en
T. T.	_			_	Г	_	_	=

Lung Disease
 Ehronic Cough

6. Heart Disease 7. Heart Murmur 8. Rheumatic Fever

9. Palpitations
10. Chest Pains
11. High Blood Pressure
12. Neurologic Impairment
13. Seizure Disorder
14. Dizziness/Fainting
15. Migraine Headaches
15. Visual Disturbances
17. Hearing Impairment

4. Shortness of Breath 5. Hay Fever

Yes	No	
		18. Speeck Defect
		19. Kidney disease
		20. Intestinal Disease
		21. Ulpers
		22. Bastric Reflux
		23. Hernia
		24. Food/Drug Allergies
		25. Latex Allergy
		26. Endocrine Disorders
		27. Thyroid Problems
		28. Diabetes
		29. Immune Disorder
		30. Skin Conditions
	П	31. Orthopedic Problems
		32. Back Problems
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Yes	No	
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		43. Drug/Alcohol Dependency
		44. Tobacco Usage
		45. Are you pregnant? EDC:
		46. Surgeries
		47. Hospitalizations
		48. Injuries
		49. Daily Medications
		SO. Other Medical Conditions

Please comment on next page on all items checked "YES". Specify number and give details.

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Page One

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





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

Please return completed form to: Orange County Community College
WELLNESS CENTER_Shepard Student Center - 2" Floor
IIS South Street, Middletown, WY 10940
Plone: (845) 344-870

NOTE:	ONLY THIS DHYSICAL	EXAMINATION FORM	WILL BE ACCEPTED -	LUSE BLACK INK ONLY

Yes	No	
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		2. Ekronic Cough
		3. Asthma
		4. Shortness of Breath
		S. Hay Fever
		8. Heart Disease
		7. Heart Murmur
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		13. Seizure Disorder
		14. Dizziness/Fainting
		15. Migraine Headaches
		16. Visual Disturbances
		17. Hearing Impairment

Yes	No		
	П	18. Speech Defect	
	П	19. Kidney disease	
		20. Intestinal Disease	
		21. Ulcers	- 1
		22. Gastrio Reflux	
		23. Hernia	- 1
		24. Food/Drug Allergies	
		25. Latex Allergy	
		26. Endocrine Disorders	- 1
		27. Thyroid Problems	- 1
		28. Diabetes	
		29. Immune Disorder	
		30. Skin Conditions	
		31. Orthopedic Problems	
		32. Back Problems	
		33. Knee or Foot Problems	
		34. Mobility Impairment	- 1

Yes	No	
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ΙП		37. Cancer
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		45. Are you pregnant? EDC:
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		47. Hospitalizations
		48. Injuries
		49. Daily Medications
		50. Other Medical Conditions
-		

Please comment on next page on all items checked "YES". Specify number and give details.

Grasge Court, Communty College is an equal apportunity of threadine action institution. In accordance with federal regulations, the New York Remark Rights Law and Section 60% of the Rehabilitation Let of 1873, Dawney County, Community, calling does not discriminate on the lassis of age, oster, religion, overed, disability, martial status, reform status, national carrier, note, gender or sexual orientation in employment or in the educational conterna and architectural orientation of countries.

Page One

- 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 on the top of page 2.



NAME:	Page	2

Personal Health History continued: Use the space below to explain any items to which you answered "YES" on page 1. Be sure to 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 liness. If ourserful under a doctor's care, give reason and name of providing.

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 Drange County Community College Wellness Center, and authorize Drange County Community College Wellness Center to release this information to my Department chair, and to the clinical sites where I am assigned, if requested. I certify that the information contained herein is true and correct to the best of my knowledge.

SECTION III -TUBERCULOSIS SCREENUS, Annual Tuberculosis screening is required. This can consist of a QuantifERON-TB Gold blood test (QFT-S) (attack a copy of blood test 1) or 2 PPO's.

All "NEW". Health Professions students require Tuberculosis Screening. This can consist of boosting with two consecutive PPO's done at least one week agant. It student provides proof of a negative PPO in the past 12 months, only one new PPO is needed now. Your most recent PPO must extend through the end of the semester to be acceptable. 2" year students need "one" PPO or if Quantiferon was done year one, student needs another Quantiferon or 2 PPO's.

PPD #1 Administered// Site Product Mfg.	lot#
Administered by (Signature)	
Date Interpreted// Signature	(within 48-72 hours)
Indurationmm Interpretation	

Second PPD should be done no sooner than one week after first.

NOTE. After baseline is established, only one annual PPD is required for continuing students in subsequents.

PPD #2 Administered//Site Product Mfg	gLat#
Administered by (Signature)	
Date Interpreted// Signature	(within 48-72 hours)
Indurationmm Interpretation	

OR

QuantiFERON-TB Gold Blood (QFT-S) Test Result:

*PLEASE ATTACH A COPY OF LAB REPORT

If PPO or QuantiFERON-TB Gold Blood (QFT-G) is Positive, a negative chest x-ray report is required. PLEASE ATTACH A COPY OF X-RAY REPORT.

CXR Date//_	Result:	
Was Chemoprophylaxis	ordered?_	

Please complete clinical evaluation if PPD is Positive.

CLINICAL EVALUATION FOR THOSE WITH HISTORY OF POSITIVE PPD or POSITIVE Quantiferon-Gold (QFT-G):

Repeat radiographs are not required for those with a history of positive PPD and recent negative chest X-ray on file. However, an Annual Clinical Evaluation by a health care professional for signs and symptoms of active TB is required.

Clinician should medically assess and counsel for the following signs and symptoms of active TB:

	YES	NO
Persistent Cough		
Fever		
Hemoptysis		
Anorexia		
Night Sweats		
Weight Loss		

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

Signature of Examining Physician, NP or PA Date

Page Two

• Be sure to SIGN where indicated.

- Note: Your signature gives the Wellness Center permission to release your medical information (immunizations and TB screening) to the chair of your department and to clinical sites where you are assigned.



NAME.	Page 2

Personal Health Kistory continued: Use the space below to explain any items to which you acrossed "YES" on page 1. De sure to list all medications you take regularly, indicate any acute or chronic medical conditions, allergies to medications, food, Listex, or other substances, and past history of surgical/medical inliess. If currently under a doctor's care, give reason and name of provider.

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Community College Wellness Center to release this information to my Department chair, and to the clinical sites where I am assigned, if requested. 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 years of age)	

SECTION III -TUBERCULOSIS SCREENUS., Annual Tuberculosis screening is required. This can consist of a QuantiFERON-TB Gold blood test (QFT-5) (attach a copy of blood test *) or 2 PPO's.

All "NEW", the life Professions students require Tuberculosis Screening. This can consist of boosting with two consecutive PPO's done at least one week agent. If student provides proof of a negative PPO in the past IC months, only one new PPO is needed now. Your most recent PPO must extend through the end of the semester to be acceptable. 2" year students need "one" PPO or if Quantiferon was done year one, student needs another Quantiferon or 2 PPO's.

PPD #1 Administered//_ Site Product 1	MfgLat #
Administered by (Signature)	
Date Interpreted// Signature	(within 48-72 hours)
Indurationmm Interpretation	-
Second PPD should be done no sooner than one week aft. NOTE: After baseline is established, only one annual PPD is subsequent years.	

PPD #2 Administ	tered/	/Site	Product Mfg.	Lat#	
Administered by (lignature)				
Pote Intercepted	, ,	P:	4.0	A (0. 77 L	

Date Interpreted _______ (within 48-72 hours)
Induration mm Interpretation

OR

QuantiFERON-TE Gold Blood (QFT-B) Test Result:

**PLEASE ATTACH A COPY OF LAS REPORT

If PPO or QuantifERON-TS Gold Blood (QFT-S) is Positive, a regative chest
x-ray report is required. PLEASE ATTACH A COPY OF X-RAY REPORT.

CXR Date/_/_ Result: Was Chemogrophylaxis ordered?	

Please complete clinical evaluation if PPD is Positive.

CLINICAL EVALUATION FOR THOSE WITH HISTORY OF POSITIVE PPD or POSITIVE Quantiferon-Gold (QFT-G):

Repeat radiographs are not required for those with a history of positive PPO and recent negative chest X-ray on file. However, an Annual Clinical Evaluation by a health care professional for signs and symptoms of active TB is required.

Clinician should medically assess and counsel for the following signs and symptoms of active TB:

	YES	NO
Persistent Cough		
Fever		
Hemoptysis		
Anorexia		
Night Sweats		
Weight Loss		

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

Signature of Examining Physician, NP or PA 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.

The Orange County Health
Department's TB Clinic offers PPD
testing for \$10 each (see schedule
included in your packet.)



take regularly, indicate any acute or chronic medical conditions, allergies to medicable surgical/medical illness. If currently under a doctor's care, give reason and name of		ast history of	
AUTHORIZATION FOR RELEASE OF INFORMATION Lunderstand that the information contained herein is for the purpose of determining Professions program. I give permission for release of this information to Brange Doc Community College Willness Center to release this information ton yellogardment oh that the information contained herein is true and correct to the best of my knowledge	nty Community College Wellness Center, an iir, and to the clinical sites where I am assi	d authorize D	range County
STUDENT SIGNATURE (Parent signature if student is under 18 years of	\		
SECTION III -TUBERCULOSIS SCREENING. A Annual Tuberculosis screening is req (AFT-9) [attach a copy of blood test*] or 2 PPO's.	wired. This can consist of a QuantiFERO	N-TE Sold blo	nod test
All "NEW". Health Professions students require Tuberculosis Screening. This can con geart. It student provides proof of a negative PPD in the gast 12 months, only one new and of the semester to be acceptable. 2" year students need "one" PPD or if Quantif PPD's.	PPD is needed now. Your most recent PPD	must extend	through the
PPD #1 Administered _ / _ / _ Site Product Mfg Lot #	CLINICAL EVALUATION FOR THOS		
Administered by (Signature)	POSITIVE PPD or POSITIVE Quant	iteron-Gold ((BFT-6):
Date Interpreted// Signature (within 48-72 hours)	Repeat radiographs are not required for		
Indurationmm Interpretation	positive PPD and recent negative chest X Annual Clinical Evaluation by a health can		
Second PPD should be done no sooner than one week after first.	symptoms of active TB is required.	e broissions	i ior signs and
NOTE: After baseline is established, only one annual PPD is required for continuing students			
is subsequent years.	Clinician should medically assess and cou and symptoms of active TB:	ınsel for the f	ollowing signs
PPD #2 Administered//_ Site Product MfgLot #	and symptoms of active to.		
Administered by (Signature)		YES	NO
Date Interpreted// Signature (within 48-72 hours)	Persistent Cough Fever		
Induration mm Interpretation	Hemoptysis		
OR .	Anorexia		
_	Night Sweats		
QuantiFERON-TB Gold Blood (QFT-G) Test Result:	Weight Loss		
*PLEASE ATTACH A COPY OF LAB REPORT	I have performed the above evaluation an Tuberculosis at this time. A negative CXF		ence of active
If PPD or QuantiFERON-TB Gold Blood (QFT-G) is Positive, a negative chest	The second of th	on ME.	
x-ray report is required. PLEASE ATTACH A COPY OF X-RAY REPORT.			
CXR Date / Result: Was Chemogrophylaxis ordered?	Signature of Examining Physician, NP or R	PA	Date

Please complete clinical evaluation if PPD is Positive

Personal Health History continued: Use the space below to explain any items to which you answered "YES" on page 1. Be sure to list all medications you

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.



Personal Health History continued: Use the space below to explain any items to which you asswered "IES" on page I. Be sure to list all medications you take regularly, indicate any acute or chronic medical conditions, allergies to medications, tood, Listes, or other substances, and past history of surgical/medical liness. If four-ently other abouts's care, give reasons and name of provider.

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(Parent signature if student is under 18 years of age)

SECTION III -TUBERCULOSIS SCREENING., Annual Tuberculosis screening is required. This can consist of a QuantiFERON-TB Gold blood test (QFT-6) (attach a copy of blood test *] or 2 FPD's.

All "NEW". Basis Professions students require Tuberrularia Screening. This can consist of boosting with two consecutive PPD's done at least one week agant. If student provides proof of a negative PPD in the past II months, selv one new PPD is needed now. Your most recent PPD must extend through the end of the semester to be acceptable. 2" year students need "one" PPD or if Quantiferon was done year one, student needs another Quantiferon or 2 PPD's.

110 21 30 miles 60_/ _/ _/ _ one 110000 mig 100 0	POSITIVE PPO
Administered by (Signature)	
Date Interpreted// Signature (within 48-72 hours)	Repeat radiographs
Induration mm Interpretation	positive PPD and rec Annual Clinical Evalua
Second PPD should be done no sooner than one week after first	symptoms of active 1
NOTE: After baseline is established, only one annual PPD is required for continuing students	2)
is subsequent years.	Clinician should medi
PPD #2 Administered//Site Product MfgLot #	and symptoms of act
Administered by (Signature)	
Date Interpreted// Signature (within 48-72 hours)	Persistent Cough
Induration mm Interpretation	Fever
	Hemoptysis
<u>OR</u>	Anorexia Night Sweats
QuantiFERON-TB Gold Blood (QFT-S) Test Result:	Weight Loss
acentrativities some ander (ar 1-8) lest nesent	Weight Loss

*PLEASE ATTACH A COPY OF LAB REPORT

If PPO or QuantifERON-TB Gold Blood (QFT-S) is Positive, a negative chest x-ray report is required. PLEASE ATTACH A COPY OF X-RAY REPORT.

CXR Date // Result: Was Chemoprophylaxis ordered?	_
Please complete clinical evaluation if PPO is Positive.	-

CLINICAL EVALUATION FOR THOSE WITH HISTORY OF POSITIVE PPD or POSITIVE Quantiferon-Gold (QFT-S):

Repeat radiographs are not required for those with a history of positive PPO and recent negative chest X-ray on file. However, an Annual Clinical Evaluation by a health care professional for signs and cometoms of active 18 is required.

Clinician should medically assess and counsel for the following signs and symptoms of active TB:

	YES	NO.
Persistent Cough		
Fever		
Hemoptysis		
Anorexia		
Night Sweats		
Weight Loss		

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

Signature of Examining Physician, NP or PA Date

Page Two

If your PPD or Quantiferon TB Gold test is POSITIVE or if 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.



	D02E #1	DOSE #2	TITERS Date + Results
MMR (Measles, Mumps, Rubella) 2 Doses required <u>OH</u> or <u>AFTER</u> 12 months of age. The second MMR vaccine must be 28 days after the first vaccine. NMR requirement is only for those born on or after OI/OI/OS. After 0I/OI/OS.			ATTACH ALL LAB RESULTS
OR OR OF THE OR			
Measles (Bubapla) - 2 doses required			Date:
			Result:
Mumps - 2 doses required			Date:
			Result:
Rubella (German Neasles) - / dose required			Date:
magne (accumin negacity) - s asset s affair as			Result:
	ricetica Deter		
Tetanus (TDAP): (recommended within past 10 years) Immu			
Meningitis (A or B): (recommended every 5 years) Immo	nization Date and Typ ned waiver required . Hepatitis B Vaccine	e:	nded for all Health Professions students.
Meningitis (A or B): (recommended every S years) Imm. Hepatitis B: Vaccine series either completed, started, or sig H waiving vaccine, waiver must be signed each year Students who DO NOT wish to receive the Hepatitis I	nization Date and Typ ned waiver required . Hepatitis B Yaccine B vaccine are <u>REQUI</u>	e: . is strongly recomme RED to sign the wain	nded for all Health Professions students. rer below.
Meningitis (A or B): (recommended every 5 years) Immo Hepatitis B: Vaccine series either completed, started, or sig If waiving vaccine, waiver must be signed each year	nization Date and Typ ned waiver required . Hepatitis B Yaccine B vaccine are <u>REQUI</u>	e: . is strongly recomme RED to sign the wain	nded for all Health Professions students. rer below.
Meningitis (A or 8): (recommended every S years) Imm. Hepatitis 8: Yaccine series eleter completed, started, or signification of the waving vaccine, waiver must be signed each year Students who DO NOT wish to receive the Hepatitis I	nization Date and Typ ned waiver requires . Hepatitis B Yaccine B vaccine are <u>REQUI</u> e #2 Results:	e: I. is strongly recomme RED to sign the wain 	nded for all Health Professions students. er below.
Meningitis (1 or B): (recommended every 5 years) Imm. Hepatitis B: Vaccine series either completed, started, or sig If walving vaccine, walver must be signed each year Students who <u>DO NOT</u> wish to receive the Hepatitis I Hepatitis B Vaccine: Dose #1	mization Date and Typ ned waiver requires Hepatitis 8 Yaccine 8 vaccine are <u>REQUI</u> #2 Results: rkers have ties, 8 and rofessions programs, ay place me at increa	e:	nded for all Health Professions students. er below. after dose three.) - QR- reased risk of exposure to blood and other Hepatiss B, a vaccine preventable disease

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.



SECTION IV: REQUIRED IMMUNIZATIONS and SEROLOGIES			
This document must be signed below by a licensed Health Care Pri			
immunization history. <u>Also acceptable</u> is an attached signed/str immunized and must submit M.D. note indicating EDC (due date).	amped Immunization re	cord from your pract	itioner. <i>Pregnant women <u>SHOULO NOT</u> be</i>
•			
REQUIRED IMMUNIZATIONS	DD2E #1	D02E #2	TITERS Date + Results
MMR (Measles, Mumps, Rubella) 2 Doses required <u>ON</u> or <u>AFTER</u> 12			ATTACH ALL LAB RESULTS
months of age. The second MMR vaccine must be 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"			
OR			1
Measles (Bulgepla) – 2 doses required			Date:
			Result:
	<u> </u>		
Mumps - 2 doses required			Date:
			Result:
Rubella (German Measles) – / dose required			Date:
			Result:
			•
VARICELLA (Chickenpox) – 2 doses required			Date:
			Result:
Tetanus (TDAP): (recommended within past 10 years) Imm	unization Date:		
Meningitis (A or B): (recommended every 5 years) Imm	ounization Date and Typ	re:	
Hepatitis B: Vaccine series either completed, started, or si	oned waiver require	i.	
If waiving vaccine, waiver must be signed each yea Students who <u>DO NOT</u> wish to receive the Hepatitis	r. Hepatitis B Vaccine	is strongly recommen	
Hanatitis R Vaccine: Note #1	ra #?	Done #3	
Hepatitis B Vaccine: Dose #1Do Hepatitis B Antibody Titer: Date:	Results:	ouse #3	
(NOTE: The COC recommends healthcare w			
		•	
Hepatitis B Waiver: As a student in one of the Health I potentially infections materials. I understand that this i Nonetheless, I decline to be vaccinated at this time. I u	may place me at incre	sed risk of acquiring	Hepatitis B, a vaccine preventable disease.
Student Signature		Date	
PRINT NAME OF HEALTHCARE PROVIDER COMPLETING THIS FOR	т.		
HEALTHCARE PROVIDER'S SIGNATURE:			DATE

Page Two

- 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



	DDSE #1	DOSE #2	TITERS Date + Results
MMR (Measles, Mumps, Rubella) 2 Doses required <u>ON</u> or <u>AFFER</u> (2 mostlis of age. The second MMR vaccine must be 28 days after the first vaccine. MMR requirement is only for those born on or after OU/OU/57. After OU/OU/58 – vaccines must be "LIVE"			ATTACH ALL LAS RESULTS
Measles (Bubasia) – 2 doses required			Date:
seames (Oddoo - a never seden en			Result:
Mumps - 2 doses required			Date:
			Result:
tubella (Serman Measles) – / dose required			Date:
			Result:
ARICELLA (Chickenpox) – 2 doses required			Date:
			Result:
Imms (TDAP): (recommended within past 10 years) Imm mingitis (A or B): (recommended every 5 years) Imm gattis B: Vaccine series either completed, started, or sig If waiving vaccine, waiver must be signed each year Students who QD NOT with to receive the Report	unization Date and Typ gned waiver requirer r. Hepatitis B Yaccine B vaccine are <u>REQUI</u>	e: . is strongly recomm RED to sign the wai	ended for all Health Professions students. ver below.
	Parelte:		
Hepatitis & Yaccine: Dose #1			
	orkers have Sep. 8 ant rofessions programs, nay place me at incres	body titer 6-8 week I am aware of my in sed risk of acquiring	s after dose three.) -OR- creased risk of exposure to blood and ot g Hepatitis B, a vaccine preventable disea

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.
 Vaccines become available in late August-early
 September, long after most physicals are due.
- The Wellness Center will host flu clinics in Middletown and Newburgh in September if classes resume on campus. If not, you will be able to obtain the vaccine from your healthcare provider or pharmacy.



The Flu Vaccine

- NURSING STUDENTS: Please provide documentation of flu vaccine for the 2020-2021 flu season to the Wellness Center by October 1st, 2020.
- Failure to do so will result in a \$25 late fee, a hold placed on your student account, and possibly lost clinical time.
- All other Health Professions students: Please provide documentation of immunization by November 1st.
- Keep a copy of your flu vaccine for your own records



REQUIRED IMMUNIZATIONS	D02E#1	DOSE #2	TITERS Date + Results
MMR (Measles, Mumps, Rubella) 2 Ooses required <u>ON</u> or <u>AFTER</u> 12- months of age. The second MMR vaccine must be 28 days after the first vaccine. MMR requirement is only for those born on or after OL/OU/57. After DI/OU/68 - vaccines must be "LIVE"			ATTACH ALL LAB RESULTS
OR			1
Measles (Rubepla) - 2 doses required			Date: Result:
Mumps - 2 doses required			Date:
			Result:
Rubella (German Neasles) - I dose required			Date:
Kubella (berman Measles) – 1 dose required			Pate:
			nesur.
VARICELLA (Chickenpax) - 2 doses required	Γ		Date:
<u>'etanus (TDAP):</u> (recommended within past 10 years) Imm	unization Date:		Result:
Meningitis (A or B): (recommended every 5 years) Imm	unization Date and Typ gned waiver require r. Hepatitis B Vaccine	ie: 1. is strongly recomme	nded for all Health Professions students.
Meningitis (A or B) (recommended every 5 years) mm Hepatitis B: Vaccine series either completed, started, or si If waiving vaccine, waiver must be signed each yea Students who <u>DO NOT</u> wish to receive the Hepatitis	gned waiver require r. Hepatitis B Vaccine B vaccine are <u>REQU</u> I	ie: i. is strongly recomme RED to sign the wai	nded for all Health Professions students. er below.
Meningitis (A or B): (recommended every 5 years) Imm Hepatitis B: Yaccine series either completed, started, or si If waiving vaccine, waiver must be signed each yea	unization Date and Tyy gned waiver require r. Hepatitis B Vaccine B vaccine are <u>REQUI</u> se #2 Results: orkers have then B and Professions programs, may place me at increa	is strongly recomme is strongly recomme RED to sign the wair Dose #3 ibody titer 6-8 week: I am aware of my in in seed risk of acquiring	nded for all Health Professions students. er below. after dose three.) • OR- reased risk of exposure to blood and other Hepatbis E, avacine preventable disease.
Meningitis (A or E): (recommended every 5 years) Imm Hepatitis B: Vaccine series either completed, started, or si If waiving vaccine, waiver must be signed each yea Students who <u>DO NOT</u> wish to receive the Hepatitis Hepatitis B Vaccine: Doz #1 Hepatitis B Antibody Titer: Data; (NOTE: The COC recommends healthcare w Hepatitis B Waiver: As a student in one of the Health potentially infections materials. I understand that this:	unization Date and Tyy gned waiver require r. Hepatitis B Vaccine B vaccine are <u>REQUI</u> se #2 Results: orkers have then B and Professions programs, may place me at increa	is strongly recomme is strongly recomme RED to sign the wait Dose #3 ibody titer 6-8 week: I am aware of my in seed risk of acquiring	nded for all Health Professions students. er below. after dose three.) • OR- reased risk of exposure to blood and other Hepatbis E, avacine preventable disease.
Meningitis (1 or E). (recommended every 5 years) Imm Hepatitis E. Vaccine series either completed, started, or si If waiving vaccine, waiver must be signed each yea Students who DO NOT wish to receive the Hepatitis Hepatitis E Vaccine: Dose #I	unization Date and Tyy gmed waiver require r. Hepatitis B Vaccine B Vaccine are REQUI E Vaccine are REQUI Results: Results: Professions programs, ray place me at increa identiand that I may r	is strongly recomme is strongly recomme RED to sign the wai Dose #3 body titer 6-8 weeks I am aware of my ini ssed risk of acquiring evoke this waiver and	nded for all Health Professions students. er below. after dose three.) • OR- reased risk of exposure to blood and other Hepathis E, avacine preventable disease. begin the vaccine series at any future date.

Page Three

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



SECTION V: PHYSICAL EXAMINATION and CLINICAL CLEARANCE FOR HEALTH PROFESSIONS STUDENTS MIDDLE NOTE: Both Page 3 and 4 of this form must be completed and signed by examining Physician, NP or PA Vision - Uncorrected: Bight 20/ Vision - Corrected: Right 20/ Underweight Does he/she wear contact lenses & Ves_____NO MOUTH-TEETH BREAST: ABDOMEN - G MUSCULOSKELETAL GU - KIDNEYS MEDICAL HISTORY (Chronic Illnesses/Hospitalizations REQUIRED EVALUATION FOR CLINICAL PARTICIPATION - To be completed by examiner Is there loss or serious impairment of any paired organ? [] NO [] YES_ Is there any limitation in normal activity? [] NO [] YES (e.g., ability to lift, walk, sit or stand for prolonged periods). If "YES", please clearly indicate the nature of the limitation and the lenoth of time you estimate it will exist, using specific dates: Is there any evidence of mental health disorder? [] NO [] YES. If "YES", please describe nature of disorder. Do you recommend further 1 YES. I have performed a complete medical examination as indicated on the above named student and found to the best of my knowledge that he/s 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 [] NO, the following active problems were identified which may interfere with the performance of his/her duties SIGNATURE and STAMP OF EXAMINING PHYSICIAN, NURSE PRACTITIONER OR PA. STAMP

Date Entered

Date Received

Reviewer

Page Four

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.



- 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



- 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.



- 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.
- 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.



- A Wellness Center Nurse will visit the mailroom on Mondays to pick up and process the physicals.
- If there are any 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, unsigned, or missing components 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 student record the nurse will EMAIL you your clinical clearance. 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 may 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 Allergies and Sensitivity

- Students with a history of Latex Allergy or Sensitivity must complete the Latex Allergy Action Plan.
- Students may obtain this form on our website: https://sunyorange.edu/wellness/forms.html
- Nursing students: Your healthcare provider must complete and sign this form due to the latex-rich environment in the simulation lab.
- All other Health Professions students may complete this form independently.



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.