MOLLOY UNIVERSITY
THE BARBARA H. HAGAN SCHOOL OF NURSING & HEALTH SERVICES

PHYSICAL FORM

Molloy University – Barbara H. Hagan School of Nursing & Health Sciences
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***Anticipated Class next semester*:**
_____ _____
Course ***Section***

Last Name_____ ***First Name*** _____
ID#_____
Maiden Name _____***Date of Birth***_____
Address _____***Gender***_____
_____***Phone*** _____

Required on Initial Physical Only: TITERS NEED TO BE DONE ONE TIME ONLY
LAB REPORTS MUST BE ATTACHED FOR EACH TITER!

Rubella Titer Value: _____ **Result:** _____ **Date:** _____

Rubeola Titer Value: _____ **Result:** _____ **Date:** _____

Varicella Titer Value: _____ **Result:** _____ **Date:** _____

Mumps Titer Value: _____ **Result:** _____ **Date:** _____

HISTORY OF VACCINATIONS: Please provide immunization dates if *Titers are Equivocal or Negative*

MMR #1 _____ **MMR #2**_____

VARICELLA #1 _____ **VARICELLA #2**_____

Hepatitis B Vaccine: HepB #1 _____ **HepB #2** _____ **HepB #3**_____

NURSING STUDENTS ARE TO BE IMMUNIZED WITH HEPATITIS B VACCINE PRIOR TOTHE BEGINNING OF CLINICAL PRACTICE OR MUST SIGN A DECLINATION STATEMENT.

DECLINATION STATEMENT

If HepB titer is Negative or Equivocal and you DO NOT have record of your immunization you must sign Declination.

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

Name (Print):_____

Date: _____ **SIGNATURE**:_____

Diptheria/TetanusPertussis: [Within Last 10 Years] (Tdap)_____ (Td)_____ If, as an adult you haven't had a vaccine that contains pertussis (whooping cough) one of **the doses you receive needs to have pertussis in it.**

I certify that _____

Is in good health as determined by a recent physical examination of sufficient scope to ensure that the student is free from health impairments which may be of potential risk to patients or other personnel or which may interfere with the performance of the student's duties, including habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter individual behavior. This individual is able to participate in clinical learning experiences as a student of Nursing.
I have identified the following:

B.P.: _____

Vision: _____ Hearing: _____

Allergy to Latex: Yes: _____ No: _____ Other Allergies: _____

Illnesses: _____

Injuries: _____

Restrictions on activity: _____

Medications: _____

Disabilities: _____
****Students with disabilities are considered on an individual basis. Students must be able to meet program objectives.**

Name of Health Care Provider:

_____

(Stamp Is Required)

Address: _____ Phone: _____

Date: _____

HEALTH CARE PROVIDER SIGNATURE: _____