

# NURSING PHYSICAL EXAMINATION (NPE)

(For Students Attending Nursing Programs)



Marcus Hall (5S) - Room 213  
718.982.3810  
nursing@csi.cuny.edu



Campus Center (1C) – Room 112  
718.982.3045  
healthcenter@csi.cuny.edu

Program:  AAS     BS     NP     DNP     New Student     Continuing Student

Last Name	First Name		
Address	City	State	Zip code
Date of Birth	EMPL ID #	Phone #	

VACCINATION	RESULT
<p><b>TUBERCULOSIS SCREENING</b>                      QuantiFERON within 1 year from end of rotation                      (end of rotation for fall: 12/23; for spring: 5/23)</p> <p><i>NOTE 1: Continuing students who renew/update their NPE form MUST provide TB QuantiFERON within six (6) months prior to first clinical session at the site. Consult the NPE Completion Schedule on the NPE instructions page.</i></p> <p><i>NOTE 2: Sea View (SEV) and South Brooklyn Health (SBH-formerly Coney Island (COI)) REQUIRE TB QuantiFERON screening <u>within sixty (60) days prior to first clinical session at the site.</u> Students may be asked to repeat TB screening.</i></p>	<p><b><u>QuantiFERON</u></b></p> <p>DATE _____</p> <p>NEGATIVE _____ INDETERM _____ POSITIVE _____  <b>(Attach copy of lab report)</b></p> <p>IF POSITIVE, DATE OF CHEST X-RAY _____</p> <p>CXR RESULTS _____ <b>(Attach copy of CXR report)</b></p>
<p>Tdap BOOSTER                      (must be within last 10 years from end of rotation)</p>	<p>DATE OF LAST Tdap BOOSTER _____</p>
<p>FLU VACCINE</p> <p><i>NOTE: South Beach Psychiatric (SBP) &amp; Silver Lake Care Center (SLK) REQUIRE <u>the flu vaccine.</u></i></p>	<p>DATE FLU VAX _____</p> <p>LOT # _____ OR</p> <p>DATE OF FLU DECLINATION _____</p>
<p>VARICELLA      1. _____                      VACCINE        2. _____</p> <p style="text-align: center;">OR</p> <p><i>NOTE: Continuing students who renew/update their NPE form MUST provide a Varicella titer lab report (not vaccine).</i></p>	<p>TITER VALUE (IGG) _____</p> <p>DOES THIS TITER CONSTITUTE IMMUNITY TO VARICELLA?  <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p><b>Equivocal/Negative titers are NOT accepted                      (Attach copy of Lab Report)</b></p>
<p>RESPIRATORY CLEARANCE</p> <p><i>(Date will grant medical clearance for student to be fit tested at the College of Staten Island.)</i></p>	<p>DATE _____</p>

Last Name\*

First Name\*

Date of Birth\*

(\*Required: Form will NOT be accepted unless Last Name, First Name and Date of Birth are filled in on 2nd page.)

VACCINATION		RESULT				
MEASLES VACCINE	1. _____	TITER VALUE (IGG) _____				
	2. _____	DOES THIS TITER CONSTITUTE IMMUNITY TO MEASLES?				
OR		<input type="checkbox"/> YES <input type="checkbox"/> NO				
<i>NOTE: Continuing students who renew/update their NPE form MUST provide a Measles titer lab report (not vaccine).</i>		Equivocal/Negative titers are NOT accepted (Attach copy of Lab Report)				
MUMPS VACCINE	1. _____	TITER VALUE (IGG) _____				
	2. _____	DOES THIS TITER CONSTITUTE IMMUNITY TO MUMPS?				
OR		<input type="checkbox"/> YES <input type="checkbox"/> NO				
<i>NOTE: Continuing students who renew/update their NPE form MUST provide a Mumps titer lab report (not vaccine).</i>		Equivocal/Negative titers are NOT accepted (Attach copy of Lab Report)				
RUBELLA VACCINE	1. _____	TITER VALUE (IGG) _____				
	2. _____	DOES THIS TITER CONSTITUTE IMMUNITY TO RUBELLA?				
OR		<input type="checkbox"/> YES <input type="checkbox"/> NO				
<i>NOTE: Continuing students who renew/update their NPE form MUST provide a Rubella titer lab report (not vaccine).</i>		Equivocal/Negative titers are NOT accepted (Attach copy of Lab Report)				
(OR) MMR VACCINE		1. _____		2. _____		
<i>NOTE: Continuing students who renew/update their NPE form MUST provide MMR titer lab reports (not vaccines).</i>						
COVID-19 VACCINE	DATE(S)	1. _____		2. _____		
	MANUFACTURER	_____		_____		
OR						
DECLINATION	DATE	_____				
HEPATITIS B VACCINE	1. _____		TITER VALUE	NEGATIVE DATE	EQUIVOCAL DATE	POSITIVE DATE
	2. _____	HbsAg				
	3. _____	HbcAB				
		HbsAB				
<i>NOTE: Continuing students who update their NPE form MUST provide a Heb B titer lab report (not vaccines).</i>		Equivocal/Negative titers are NOT accepted (Attach copy of Lab Report)				

I certify that the above student has had a complete physical examination and risk assessment that is of sufficient scope to ensure that the participant is free from any health impairment which is of potential risk to patients or which might interfere with the performance of their duties. As such, this student is cleared to participate in clinical rotations at a hospital, nursing home, community or private health facility supervised by the College of Staten Island's Nursing Program faculty.

Health Care Provider's Name and Title

Date of Clearance

Address

Telephone Number

Health Care Provider's Signature and Stamp