NURSING PHYSICAL EXAMINATION (NPE)

(For Students Attending Nursing Programs)

College of Staten Island The City University of New York Health & Wellness Services	**Health & Wellness Services** **2800 Victory Blvd, 1C, Room 112** **Staten Island, NY 10314**	**Telephone 1.718.982.3045** **Fax 1.646.664.3987** **TTY 1.718.982.3315**

Program: ☐ **AAS** ☐ **BS** ☐ **NP** ☐ **DNP** ☐ **New Student** ☐ **Continuing Student**

Last Name **First Name**

Address **City** **State** **Zip code**

Date of Birth **EMPL ID #** **Phone #**

TEST / VACCINATION	RESULT
TUBERCULOSIS SCREENING **QuantiFERON within 1 year from end of rotation** **(end of rotation for fall: 12/23; for spring: 5/23)** ***NOTE: Sea View (SEV) and South Brooklyn Health (SBH-formerly Coney Island (COI)) REQUIRE QuantiFERON screening within 60 days prior to first clinical session at the site. Students may be asked to repeat TB screening.***	**QuantiFERON** DATE _____ NEGATIVE_____INDETERM_____POSITIVE _____ **(Attach copy of lab report)** IF POSITIVE, DATE OF CHEST X-RAY _____ CXR RESULTS_____**(Attach copy of CXR report)**
Tdap BOOSTER **(must be within last 10 years from end of rotation)**	DATE OF LAST Tdap BOOSTER _____
FLU VACCINE ***NOTE: South Beach Psychiatric (SBP) & Silver Lake Care Center (SLK) REQUIRE the flu vaccine.***	DATE OF FLU IMMUNIZATION _____ OR DATE OF FLU DECLINATION _____
VARICELLA VACCINE 1. _____ 2. _____ OR ***NOTE: South Beach Psychiatric (SBP) REQUIRES titers.***	TITER VALUE (**IGG**) DOES THIS TITER CONSTITUTE IMMUNITY TO VARICELLA? ☐ **YES** ☐ **NO** **Equivocal/Negative titers are NOT accepted** **(Attach copy of Lab Report)**
RESPIRATORY FIT TEST CLEARANCE (***Date will grant medical clearance for student to be fit tested at the College of Staten Island)***	DATE _____

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)

TEST / VACCINATION	RESULT
MEASLES VACCINE 1. _____ 2. _____ OR *NOTE: South Beach Psychiatric (SBP) REQUIRES titers.*	TITER VALUE (**IGG**) _____ DOES THIS TITER CONSTITUTE IMMUNITY TO MEASLES? ☐ **YES** ☐ **NO** **Equivocal/Negative titers are NOT accepted (Attach copy of Lab Report)**
MUMPS VACCINE 1. _____ 2. _____ OR *NOTE: South Beach Psychiatric (SBP) REQUIRES titers.*	TITER VALUE (**IGG**) _____ DOES THIS TITER CONSTITUTE IMMUNITY TO MUMPS? ☐ **YES** ☐ **NO** **Equivocal/Negative titers are NOT accepted (Attach copy of Lab Report)**
RUBELLA VACCINE 1. _____ 2. _____ OR *NOTE: South Beach Psychiatric (SBP) REQUIRES titers.*	TITER VALUE (**IGG**) _____ DOES THIS TITER CONSTITUTE IMMUNITY TO RUBELLA? ☐ **YES** ☐ **NO** **Equivocal/Negative titers are NOT accepted (Attach copy of Lab Report)**
(*or*) MMR VACCINE *NOTE: South Beach Psychiatric (SBP) REQUIRES titers.*	1. _____ 2. _____
COVID-19 VACCINE DATE(S) MANUFACTURER OR DECLINATION DATE	1. _____ 2. _____ _____ _____ _____
HEPATITIS B VACCINE 1. _____ 2. _____ 3. _____ *NOTE: South Beach Psychiatric (SBP) REQUIRES titers.*	

	TITER VALUE	NEGATIVE DATE	EQUIVOCAL DATE	POSITIVE DATE
HbsAg				
HbcAB				
HbsAB				

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