NCC-ID#: N00_____ NAME: _____
Print (Last) (First) (M.I.)

Required on Initial Physical Only:

Documentation of Immunity to Measles, Mumps, Rubella and Varicella by blood antibody testing or adequate documentation of immunizations required. ***Dated original lab report MUST be attached.***

Measles/Rubeola Titer_____ Date: _____Result: _____**OR** Vaccine 1st Date:_____ 2nd Date: _____
Mumps Titer _____Date: _____Result: _____**OR** Vaccine 1st Date:_____2nd Date:_____
Rubella Titer _____Date: _____Result: _____**OR** Vaccine Date:_____
Varicella Titer_____Date: _____Result: _____**OR** Vaccine 1stDate:_____ 2nd Date: _____

Tdap or Td Booster within ten years, _____

Date: Hepatitis B Vaccine: 1st Date:_____ 2nd Date: _____3rd Date: _____ or Titer: _____

ALLIED HEALTH AND NURSING STUDENTS ARE ADVISED TO BE IMMUNIZED WITH HEPATITIS B VACCINE PRIOR TO THE BEGINNING OF CLINICAL PRACTICE OR MUST SIGN A DECLINATION STATEMENT.

DECLINATION STATEMENT

I understand that during my participation in my clinical internship, I may be exposed to blood or other potentially infectious materials and 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. I understand that Nassau Community College cannot mandate that I take this vaccination in order to continue my education in my chosen health science program. My failure to be immunized could jeopardize the successful fulfillment of the requirements of my program at Nassau Community College, which may preclude me from graduating. I further understand and agree that I cannot hold Nassau Community College responsible for any injury or illness arising from my activity and/or exposure to blood or other blood-borne pathogens in my program and clinical laboratories.

Name (Print): _____
Student Signature: **X**_____ Date: _____

PHYSICIAN'S CERTIFICATION:

I hereby certify that the above named person is in good health as determined by a recent physical examination of sufficient scope to ensure that he or she is free from health impairments which may be of potential risks to patients and other personnel or which may interfere with the performance of his or her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior. This individual is able to participate in their clinical learning experiences.

Provider Please √ Check: □ CLEARED FOR PROGRAM or □ NOT CLEARED FOR PROGRAM

_____
_____
_____
_____

Physician's Signature _____ ** **Date:** _____
**Do Not Date Physical until PPD is Read
Physician's Name (Print) _____ License No. _____
Physician's Stamp (Required) _____Phone (_____)_____
Address: _____
(Rev. 3/17) (ALL INFORMATION IS CONFIDENTIAL)

STUDENTS MUST ENSURE THEY HAVE PHOTOCOPIES OF ALL PAPERWORK BEFORE HANDING IN FOR BLUE SLIP. CLINICAL INSTRUCTORS AND FACILITIES WILL REQUIRE COPIES LATER ON. THE HEALTH OFFICE WILL NOT MAKE COPIES IF STUDENTS FAIL TO DO SO."