Phone: 518-464-8500 or toll free: 888-647-2388 or fax 518-464-8777 Attn: CPNE



# **Instructions for Completion School of Nursing Health Status Report**

#### All items must be completed on Health Status Report for form to be accepted

A physical examination is required by a physician, physician's assistant, or a nurse practitioner within 12 months of exam date.

I. Allergies	List any allergies (Latex allergies, if you require latex free gloves you must complete a <b>Request for Accommodation Form</b> found at		
	<u>www.excelsior.edu/disability_services.</u> Questions regarding accommodations can be directed to the Disability Services Office at		
	dsc@excelsior.edu.		
II. Tetanus/diphtheria	Provide date of last TD Booster. Must be within 10 years of exam date.		
III. Tuberculosis	Provide date of BCG Vaccine or last PPD. Negative PPD must be		
PPD (Mantoux)	within 1 year of exam date. Students who have received the BCG		
	vaccine or have a positive PPD must provide date and results of most		
	recent chest X-ray. Chest X-ray must be dated after positive PPD.		
IV. Measles/Mumps/Rubella (MMR)	If born in 1957 or later provide dates of 2 MMR vaccinations, at least		
First Available in US in 1963	4 weeks apart <u>or</u> evidence of serologic immunity (+ Titre) <u>or</u> history		
	of Measles and/or Mumps. Documented history of Rubella is not		
	acceptable.		
	If born prior to 1957, provide date of 1 MMR vaccination <u>or</u> serologic		
	evidence of immunity (+ Titre) or history of Measles and/or Mumps.		
	Documented history of Rubella is not acceptable.		
V. Varicella (chickenpox)	Provide dates of 2 varicella vaccinations, 4 weeks apart <u>or</u> serologic		
Widely available in US in 1995	evidence of immunity <u>or</u> history of varicella disease.		
VI. Hepatitis B	Provide date of completion of 3-dose series of Hepatitis B vaccine or		
	Serologic evidence of immunity or to decline the vaccination, provide		
	signatures of student and an adult witness and date signed.		
VII. Student Signature	Student's signature is required.		
	Please note: You must update the College with any changes to		
	your health status as soon as possible before your CPNE.		
VIII. Physical Examination:	A physical examination is required by a physician, physician's		
	assistant, or a nurse practitioner within 12 months of exam date.		
	Date of Physical exam, Signature, printed name and phone number of		
	Health Care Provider is required.		

### Please do not send copies of laboratory results with the Health Status Report.

If you are updating health information, please do so on your original health status report and resubmit.



7 Columbia Circle, Albany, NY 12203-5159

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#### School of Nursing Health Status Report

## This form must be filled out completely for your application to be accepted DO NOT SUBMIT COPIES OF LABORATORY RESULTS

Students who require any accommodation(s) to complete the examination should go to <a href="www.excelsior.edu/disability\_services">www.excelsior.edu/disability\_services</a> to access a **Request for**Accommodation **Form** and our policy and procedure statement.

Student's Name:		Student ID#	DOB:	
I. List any allergies (Latex allergies, if you require latex free gloves, please contact the office of Disability Services. See instructions page.)				
II. Diphtheria/Tetanus Booster Date (Within 10 years of student's performance exam date)/				
_		MM	DD YY	
III. Tuberculosis Screening (must be within	n 12 months of exam date)			
	D (Mantoux): REQUIRED if 1		Ray: Only if Documented BCG or (+)PPD	
Date://OR Date	e:// MM DD YY	Date of r	nost recent chest x-ray://	
	sults: ☐ Negative ☐ *Positive	*Requires Result of Chest X-Ray	MM DD YY  chest x-ray: □ Negative □ Positive	
IV. Measles/Mumps/Rubella - Immunity required as evidenced by:				
MMR Vaccinations:	Measles (Rubeolla) Tit	re Results:	<b>Documented history of Measles</b>	
(2 required in a lifetime, if born in or after 1957)	☐ Immune		OR	
Date 1:/				
MM DD YY	Mumps Titre Results:  OR □ Immune		Documented history of Mumps	
Date 2://	OR ☐ Immune		<i>OR</i> □ Yes, Year	
(1 required if born prior to 1957) Date:/	Rubella (German Mea  ☐ Immune	sles) Titre Results:	Documented history not acceptable for Rubella. Need vaccine or titre.	
MM DD YY				
V. Varicella (Chicken Pox) - Immunity	required as evidenced by:			
Varicella Vaccinations(2 required): Date 1:/	OR Titre Results:	OR Documente	ed History of Varicella or Herpes Zoster:	
Date 2: // MM DD YY	☐ Immune	History: □	Yes, Year	
VI. Hepatitis B: *Hepatitis B Vaccine Declination: I understand that due to my occupational exposure to blood or				
Series (3) completed			or acquiring the hepatitis B virus (HBV)	
Date: $\frac{\sqrt{\frac{1}{MM}}}{\sqrt{DD}} \frac{\sqrt{YY}}{YY}$	infection. I have been informed of the recommendation that all health care workers be vaccinated with hepatitis B vaccine. However, I decline hepatitis B vaccination at this time. I understand that			
OR			hepatitis B, a serious disease.	
☐ Immune (Titre Results)	•	•	•	
<b>OR</b> Declined Vaccination	Student.		Date: MM/DD/YY	
			·	
☐ Yes ( <b>If yes, sign declination and</b> have witnessed.)	(age 21 or olde	r)	MM/DD/YY	
VII. My signature verifies, to the best of my knowledge, that all above data is correct. I understand this information may be released to the clinical facility(s) where the graded activity is administered. If I encounter a change in my health status, I will notify the College as soon as possible before my exam.				
Student's Signature				
VIII. Physical Examination: My signature below confirms that I have examined the above named individual and found him/her to be in satisfactory physical condition to care for patients across the lifespan.				
Date of Physical Examination: / / (must be within 12 months of CPNE exam date or capstone experience)				
Date of Physical Examination:// (must be within 12 months of CPNE exam date or capstone experience)  Signature of Health Care Provider:				
Printed Name of Health Care Provider:				
Provider Telephone #: ()				