Mandatory

Nursing Program Clearance Check Sheet

The following information is required for your clinical clearance within the Nursing Program. Failure to meet these requirements will result in the forfeiture of your seat in the Nursing Program. All clearance information must be submitted by **AUGUST 02, 2021**.

Health Clearance

At this time, all clearance documents must be submitted electronically via email to the Office of the Dean, School of Health Professions & Natural Sciences, at hpns@ccm.edu. Please do not send health clearance documents to the Nursing Department.

It is the student’s responsibility to ensure all scanned documents are complete and legible. **Students should retain original documents for their personal records.**

- All nursing students are required to have a complete physical examination, including certain blood tests and immunizations. *(Upon entrance into the program or reinstate)*
  - Students need to present laboratory evidence of immunity to Measles, Mumps, Rubella, Varicella and Hepatitis B
- Proof of flu shot is required. *(Yearly)*
- Proof of PPD *(Yearly)*
- Urine Drug screening test is required. *(Upon entrance into the program or reinstate)*
- Health Insurance Attestation Form *(Upon entrance into the program)*
- Malpractice Insurance. *(Yearly)*
  - Must show 1,000,000 to 6,000,000 dollar aggregate
  - Registered Nurse Student Code
  - LPN and Registered Nurse Student Code (if student has current LPN license)
- CPR
  - BLS for Healthcare Provider
  - American Heart Association only
  - Heart Saver and American Red Cross are unacceptable

Students will not be able to register for the Nursing classes until this information is recorded with the Dean’s office.

**Please remember to complete your annual Criminal History Background Check (if required) between the dates of JULY 01 and JULY 09, 2021. Contact the Nursing Department (nursingdepartment@ccm.edu) with any questions about this process.**

If you have any questions regarding your health clearance, refer to the Clinical Clearance Requirements Handbook available on the Nursing Department web page at: [https://www.ccm.edu/wp-content/uploads/pdf/nursing/Guidelines-for-clinical-clearance.pdf](https://www.ccm.edu/wp-content/uploads/pdf/nursing/Guidelines-for-clinical-clearance.pdf) OR contact the HPNS Office of the Dean at hpns@ccm.edu.
COUNTY COLLEGE OF MORRIS
Health Programs MEDICAL HISTORY AND PHYSICAL EXAMINATION

TO BE COMPLETED AND SIGNED BY STUDENT:

Last Name_________________________ First Name_________________________ MI ___________ Student ID_________________________

Student Email_________________________ Phone_________________________ Date of Birth_________________________ Age__________

Drug Allergies ___________________________ Food Allergies/Intolerance ___________________________

Does student require EpiPen? □ Yes □ No Has student been trained in its use? □ Yes □ No

Medications (Please include prescription medications and any over-the-counter medications taken daily) ___________________________

Past Medical History ___________________________

Name of Emergency Contact ___________________________ Relationship ___________________________

Home Phone ___________________________ Cell/Work Phone ___________________________

Signature of Student ___________________________ Date ___________________________

TO BE COMPLETED AND SIGNED BY LICENSED HEALTHCARE PROVIDER: The information requested by the College is strictly for the use of authorized personnel and will not be released without the student’s consent.

Male____ Female_____ Height___________ Weight___________ Blood Pressure___________

Heart Rate___________ Hearing within Normal Limits □Yes □No Vision Right 20/_______ Left 20/_______

Corrective Lenses □ Yes □ No Color Blind □ Yes □ No

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<thead>
<tr>
<th>System</th>
<th>Satisfactory</th>
<th>Unsatisfactory</th>
<th>Details if Unsatisfactory</th>
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</thead>
<tbody>
<tr>
<td>HEENT</td>
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<td>Respiratory</td>
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<td>Metabolic/Endocrine</td>
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<td>Neuropsychiatric</td>
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<td>Skin</td>
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Student is cleared for all physical activities without limitations. □ Yes □ No

If no, please explain why ___________________________

Licensed Healthcare Provider’s Name ___________________________ Date of Exam ___________________________

Signature of Licensed Healthcare Provider ___________________________ Print ___________________________

Address ___________________________ Phone ___________________________

6.5.19 revised
6.1.18 New
COUNTY COLLEGE OF MORRIS
Health Programs IMMUNIZATION RECORD

Last Name_________________________ First Name_________________ MI _______ Student ID_________________________

Student Email_________________________ Phone_________________ Date of Birth_________________ Age_________________

TO BE COMPLETED AND SIGNED BY A LICENSED HEALTHCARE PROVIDER: All students must have titers* drawn. All laboratory reports must be attached for Rubeola (Measles), Mumps, Rubella, Varicella and HBsAb titers. Equivocal findings are documented as negative immunity.

*Past Titer Results are acceptable. Titors do not need to be repeated.

<table>
<thead>
<tr>
<th>Test</th>
<th>Drawn</th>
<th>IgG Titer Value</th>
<th>Revaccination* Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rubeola (Measles)</td>
<td>Date_________</td>
<td>Value_______ □ Positive □ Negative</td>
<td>(Re)vaccination #1 Date____________________ (with documented series)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>(Re)vaccination #2 Date____________________ (without documented series)</td>
</tr>
<tr>
<td>Mumps</td>
<td>Date_________</td>
<td>Value_______ □ Positive □ Negative</td>
<td>(Re)vaccination #1 Date____________________ (with documented series)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Revaccination #2 Date_____________________ (without documented series)</td>
</tr>
<tr>
<td>Rubella</td>
<td>Date_________</td>
<td>Value_______ □ Positive □ Negative</td>
<td>Revaccination #1 Date_____________________ (If Titer is Negative or Equivocal)</td>
</tr>
<tr>
<td>Varicella</td>
<td>Date_________</td>
<td>Value_______ □ Positive □ Negative</td>
<td>(Re)vaccination #1 Date____________________ (with documented series)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Re)vaccination #2 Date____________________ (without documented series)</td>
</tr>
<tr>
<td>Hepatitis B (HBsAb)</td>
<td>Date_________</td>
<td>Value_______ □ Immune □ Not-Immune</td>
<td>If HBsAb titer shows immunity, the student does not need to complete the three Hepatitis vaccine series. If HBsAb titer does not show immunity, three (3) documented doses of Hepatitis B vaccine must be presented or administered.</td>
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<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td>Dates of Vaccinations</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Three (3) doses of Hepatitis B vaccine administered intramuscularly at 0, 1 and 6 months.</td>
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<td></td>
<td>#1</td>
</tr>
<tr>
<td>Tdap</td>
<td>Date_________</td>
<td></td>
<td>Student must have received a Tdap vaccine at 11 years of age or older.</td>
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</tbody>
</table>

*Based on CDC recommendations for Healthcare Professionals

Licensed Healthcare Provider’s Name__________________________________________ Date of Exam_________________

Print

Signature of Licensed Healthcare Provider_____________________________________

Address_________________________________________ Phone_________________

6.1.18 New
9/19/19 revised
COUNTY COLLEGE OF MORRIS
HEALTH PROGRAMS ANNUAL TUBERCULOSIS SCREENING

Last Name_________________________________________ First Name_________________________ MI_ Student ID __________________________

Student Email_____________________________________ Phone__________________________ Date of Birth_________________ Age_____

TO BE COMPLETED AND SIGNED BY A LICENSED HEALTHCARE PROVIDER: Either a Mantoux TB (PPD) skin test OR an interferon gamma release assay (IGRA) blood test such as QuantiFERON Gold® or T-SPOT® is acceptable. A two-step PPD is necessary unless a PPD was done in the last calendar year. If a one-step PPD was done, documentation of the previous one-step done within the past calendar year must be attached. **PPD RESULTS MUST BE RECORDED IN mm**

Two-Step PPD (Mantoux) (Date Read must be within 72 hours)

PPD #1 Date Administered______________ Site __________ Date Read*__________ Result ______________

**PPD #2 (administered 1 to 3 weeks after PPD #1) is required unless student provides proof of a previous negative PPD within 1 year of the date of PPD #1.**

PPD #2 Date Administered______________ Site ______________ Date Read*__________ Result ______________

*Date Read Must Be Within 72 hours

One-Step PPD (Mantoux)

Documentation of previous one-step done within the past calendar year must be attached.

PPD #1 Date Administered______________ Site __________ Date Read*__________ Result ______________

*Date Read Must Be Within 72 hours

OR

IGRA (QuantiFERON)—TB Gold® or T-Spot® Blood Test

Date Reported______________ Result_________________________ Lab Report Must Be Attached

PPD or QuantiFERON® or T-Spot® Positive Findings

Positive Result: If positive, a negative post-positive chest x-ray is required. This is a one-time only requirement as long as student is asymptomatic. An IGRA blood test is recommended for subsequent tuberculosis screening.

Chest x-ray has been documented post-positive result? ☐  Report Date________________ Report Must Be Attached

☐ Normal Chest x-ray

☐ Abnormal Chest x-ray  ☐ Patient was/is treated with prophylactic medication. Date treatment started __________

Licensed Healthcare Provider's Name_________________________________________ Date________________

Signature of Licensed Healthcare Provider________________________________________________

Address ___________________________________________________ Phone__________________________

__________________________________________________________

6.1.18 New
COUNTY COLLEGE OF MORRIS
Health Programs ANNUAL INFLUENZA VACCINATION

Last Name__________________________  First Name__________________________  MI  Student/Faculty ID__________________________

Student/Faculty Email__________________________  Phone__________________________  Date of Birth__________________________  Age__________________________

TO BE COMPLETED AND SIGNED BY A LICENSED HEALTHCARE PROVIDER
If documentation is being sent that includes all the information below, then indicate “See attached”.

Date of Vaccine Administration__________________________

Manufacturer_________________________________________  Product Name_________________________________________

Lot__________________________________________________  Expiration Date________________________________________

Dose__________________________________________________  Injection Site________________________________________

Licensed Healthcare Provider’s Name_________________________________________  Title______________

Signature of Licensed Healthcare Provider________________________________________

Address_________________________________________  Phone________________________________________

NOTE:
For students admitted in the fall, vaccination must be administered by October 1st each year.

For students admitted in the spring, vaccination must be administered by December 31st if not previously vaccinated prior to admission and by October 1st for each year thereafter.

6.1.18 New
9.16.2020 Rev
An 11-panel drug screen is mandatory for all students doing their clinical rotations at healthcare facilities. The screen includes the drugs listed below.

<table>
<thead>
<tr>
<th>Amphetamines</th>
<th>Barbiturates</th>
<th>Benzodiazepines</th>
<th>Cannabinoids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cocaine</td>
<td>Opiates</td>
<td>Phencyclidine</td>
<td>Methadone</td>
</tr>
<tr>
<td>Propoxyphene</td>
<td>Meperidine</td>
<td>Tramadol</td>
<td></td>
</tr>
</tbody>
</table>

Failure to submit to drug screening will result in dismissal from the program. The drug screening MUST be completed at FastER Urgent Care (flyer attached). The cost is $60 payable on the day of testing. The student must bring this form to FastER Urgent Care and have it signed below by a FastER Urgent Care representative and submit it to the Administrative Assistant for Health Professions. Test results are sent directly to the College by FastER Urgent Care. For questions, students should refer to the Student Handbook or contact the Administrative Assistant for Health Professions.

As part of my pre-clinical requirement to ensure I am physically able to perform the clinical component of my program, I am required to provide a urine sample for an 11-panel drug screen to determine my status for illegal drug use.

I, ________________________________, consent to providing a sample of my urine to be tested for drug content at FastER Urgent Care.

TO BE SIGNED BY A FastER URGENT CARE REPRESENTATIVE

Representative’s Name ________________________________ Date of Test ____________________

Signature of Representative ________________________________

Address ________________________________ Phone ____________________
FastER Urgent Care is located across the street from the Alfred Vail School at 130 Speedwell Avenue on the corner of Mill Road in Morris Plains. We provide walk-in no appointment needed medical care to children and adults for a wide range of illness and injuries including:

- Cough/Colds/Flu/Strep Throat
- Ear Aches
- Fractures/Dislocations
- Sprains/Strains
- Lacerations, Burns and Skin Infections
- Urinary Tract Infections
- Gyn problems and STD Testing
- Vomiting/Diarrhea
- School/Camp/Sports/Work and Routine Physicals

We have onsite x-ray and rapid testing for strep, pregnancy, and flu, and full lab services.

**Open Monday-Friday 8am-8pm**

**Saturday and Sunday 8am-4pm**

**Major Holidays 9am-1pm**

*Drug Testing stops at 5pm on weekdays and 1pm on weekends*
I, ______________________________, attest that as required by County College of Morris, I have a current health insurance plan which I will maintain through the entirety of my enrollment in the professional phase of the Nursing, Radiography, Respiratory Therapy and/or other health-related program that require participation in a clinical experience. I understand that at any time I may be required to present proof of my health insurance plan.

Student Signature_____________________________ Date____________________

COUNTY COLLEGE OF MORRIS
Health Programs AUTHORIZATION FOR MEDICAL RELEASE

I, ______________________________, authorize County College of Morris to release and disclose any and/or all pertinent medical information contained in my health clearance packet to the clinical facility and/or regulating agency that requires this information as a condition of my assignment to the facility.

This document will remain in effect through the entirety of my enrollment in the professional phase of the Nursing, Radiography, Respiratory Therapy and/or other health-related program for up to a two-year period from the date of signature.

Student Signature_____________________________ Date____________________
COUNTY COLLEGE OF MORRIS

CRIMINAL HISTORY BACKGROUND CHECK AND DRUG and ALCOHOL SCREENING
STUDENT ACKNOWLEDGEMENT FOR STUDENTS IN THE CLINICAL PHASE OF THE HEALTH PROFESSIONS PROGRAMS

I acknowledge that I have received written notification informing me that all students enrolled in clinical courses will be required to submit to a Criminal History Background Check (CHBC) and Urine Drug Screening as mandated by the clinical affiliation agreements.

The CHBC will occur on an annual basis. If there is a record found or a positive result, admission into the professional phase of the program may be denied. If at any time after acceptance into the professional phase of the program a student has a positive CHBC, it may result in dismissal from the program.

It is the policy of the Nursing, Radiography and Respiratory Therapy Programs that students report any arrest or conviction immediately to the department chairperson and that this information will be reported to the security services director (or other designated person) at the clinical site to which the student is assigned.

An 11-panel Urine Drug Screening will be performed upon acceptance into the clinical phase of the program. In the event of behavior deemed inappropriate or suspicious in any clinical course, the College reserves the right to refer the student for a random drug and alcohol screen. All costs of initial and additional screenings will be incurred by the student. Positive results may be cause for immediate dismissal from the program. Refusal to submit to drug and alcohol screenings will result in dismissal from the program. Campus Regulations regarding alcohol and drugs also apply.

Reinstated students must have a repeat CHBC and Urine Drug Screening completed upon re-entry into the program.

When a graduate applies for licensure as a registered nurse, radiologic technologist or respiratory therapist in New Jersey, another CHBC will be performed. If the CHBC reveals a conviction, a review of the offense by the licensing and/or credentialing board may be required and may delay the licensure or credentialing process.

__________________________________________  __________________________
Signature                                              Date

__________________________________________  __________________________
Print Name                                               Student ID #

Program

Revised 10.29.2018mm