HOFSTRA NORTHWELL
SCHOOL of NURSING
AND
PHYSICIAN ASSISTANT STUDIES

Dear Student,

Student Health Services congratulates you on your acceptance. As we welcome you into this academic and healthcare environment, New York State Department of Health (NYS DOH) requires that certain medical evaluations are completed prior to starting your clinical school education.

Prior to beginning school or completing the medical clearance requirements at our office, you are required to visit your primary care provider for the necessary bloodwork and screening. Completing the following documentation is necessary to attend mandatory orientation. Student Health Services (SHS) medical clearance is a mandatory requirement. Medical clearance and proof of vaccinations should be uploaded to your Hofstra Portal in the MediCat Icon. Should you not have access to a primary care provider a physical examination appointment may be made at the Student Health Services for a nominal fee. This SHS appointment will include the following evaluations:

- Physical Examination
- Respirator Fit Testing
- Vaccinations as necessary

Here is a complete list of requirements that will need to be completed by each student. The following page will give you step by step instructions on how to complete each requirement.

MEDICAL CLEARANCE REQUIREMENTS

Physical Exam	• **Physical Exam** and **Health History** within the past year
MMR & Varicella& Tetanus, Diptheria & Pertusis Immunizations & Proof of Immunity (recommended)	•Proof of immunity or adequate vaccination to Measles, Mumps, Rubella, Varicella and Tetanus/Diphtheria/Pertussis •Proof of immunity can be satisfied by a Certificate of Immunization or an official laboratory report with titer results indicating immunity •For Varicella only, documented proof of previous diagnosis is acceptable
Meningococcal vaccine	•**Proof of vaccination against the Meningococcal Disease** or documented acknowledgment of the disease risks and refusal
Tuberculosis Screening	•**Latent TB infection can be screened using either of the following NYSDOH methods**: •Tuberculin Skin Testing (TST) •Food and Drug Administration (FDA) approved blood assays for the detection of latent TB Infection (e.g., QuantiFERON TB Gold)
Respirator Fit Testing	•Students with facial hair that interferes with the respirator's seal to your skin cannot be fit tested with the respirator. Be sure that facial hair in those areas are removed prior to fit testing.

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Here is what you need to do to ensure your medical clearance is completed on time:

Section 1: Complete & Submit Medical Clearance Documents

- Complete the Hofstra University Medical Record form, Demographic Profile/ Medical Evaluation Acknowledgement, Respirator Medical Evaluation & Tuberculosis Screening Questionnaire's, Physical Examination and Immunization Record.
- **Deadline: Complete & Upload all Medical Records Form online through your Medicat icon found in your Hofstra Portal at the assigned deadline**

Section 2: Bloodwork & Vaccinations

- **Deadline:** All vaccinations and required titers must be completed no later than **July 27.**
- **PPD not required for students that are Northwell Employees as an annual screening/risk assessment is completed via the Northwell Employee Health Service**
- **All non Northwell employees must complete PPD by July 27**

Section 3: Schedule Appointment if Necessary

- Schedule your medical clearance appointment at Student Health Services if necessary.
- **Deadline:** Students must call SHS to schedule an appointment before **July 15.** Appointment's will be scheduled during the following time period: July 1-August 1. Please plan appropriately. Appointments are limited, call ASAP to secure an appointment date should a physical examination be necessary.

Reminders:

- **Bloodwork if applicable, must be completed before you schedule your medical clearance appointment at SHS.**
- **Bring valid unexpired identification to your medical clearance appointment.**

Please feel free to contact us if you have any questions or concerns regarding any of the medical requirements.

Student Health Services
Hofstra University, 250 Hempstead Blvd, Hempstead, NY 11549
Phone: (516) 463-6745
Fax: (516) 463-5161
SHACC@hofstra.edu
Hours of Operation: Mon-Thur: 9 AM-7 PM, Fri: 9 AM-6 PM, Sat & Sun: 10 AM-6PM

June 23 2022 BC

HOFSTRA NORTHWELL
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TO BE COMPLETED BY THE STUDENT

- ☐ Hofstra University Medical Record Form in MediCat
- ☐ Respirator Medical Evaluation Questionnaire
- ☐ Tuberculosis Screening Questionnaire
- ☐ Physical Examination to be completed by your private provider using form below *(If you are unable to get the physical examination done, we will perform the physical examination at your SHS appointment)*

2022

DONALD AND BARBARA ZUCKER SCHOOL of MEDICINE AT HOFSTRA/NORTHWELL

HOFSTRA NORTHWELL SCHOOL of NURSING AND PHYSICIAN ASSISTANT STUDIES

Hofstra Medical Record

TO THE STUDENT: THIS INFORMATION WILL BECOME PART OF YOUR CONFIDENTIAL HEALTH RECORD.

1. Print Name _____
   Last First Middle

2. Address _____
   Street/Apt. # City State Zip Code

3. Date of Birth _____ Country of Birth _____ Hofstra ID # _____

4. Person to identify in case of emergency _____ ☐ Parent ☐ Guardian ☐ Spouse ☐ Other _____

   Address _____ Phone ( ) _____
   Street/Apt. # City State Zip Code

5. Home Phone ( ) _____ Cell Phone ( ) _____ Email Address _____ @ _____

6. Name of Health Insurance Carrier _____ I.D. No. _____

   Address of Insurance Company _____ Group No. _____

   Subscriber/Cardholder Name _____ ☐ Parent ☐ Guardian ☐ Self ☐ Spouse

7. Indicate Student Status: ☐ Undergraduate ☐ Graduate ☐ Law
   ☐ Full time ☐ Part Time ☐ Medical

8. Are you a member of an athletic team? ☐ Yes ☐ No If yes, indicate sport: _____

9. Consent for Treatment:

REQUIRED OF ALL STUDENTS OR PARENT/GUARDIAN FOR STUDENTS UNDER THE AGE OF 18:

I _____ hereby consent to the following:
Hofstra's Health and Wellness Center may hospitalize me (my child) or may perform any medical or surgical procedures or tests deemed necessary in my (my child's) care and treatment. Hofstra's Health and Wellness Center may present information concerning my (my child's) medical condition to the other responsible University officials when deemed necessary. Hofstra's Health and Wellness Center may forward any and all of my (my child's) medical records to physicians and/or hospitals when deemed necessary for my (my child's) proper care and treatment.

_____ _____
Signature of Student or Parent/Guardian Date

10. **REQUIRED BY NEW YORK STATE LAW:**
    TO BE COMPLETED AND SIGNED BY STUDENT OR PARENT/GUARDIAN FOR STUDENT UNDER THE AGE OF 18.
    CHECK **ONE** ONLY

    _____ I (my child) had the meningococcal meningitis immunization within the past 10 years. Month _____ / Year _____

    _____ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I (my child) with obtain immunization against meningitis within 30 days of the beginning of the semester.

    _____ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I (my child) understands the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal disease.

_____ _____
Signature of Student or Parent/Guardian Date

MEDICAL HISTORY TO BE COMPLETED BY STUDENT

Confidential

Name of Student_____ Date of Birth_____ Hofstra ID #_____

FAMILY MEDICAL HISTORY

Check each item:	Yes	No	Relationship	Check each item:	Yes	No	Relationship
Tuberculosis (If yes, give details on additional sheet)				Nervous or mental disorder			
Diabetes				Thyroid disease			
High blood pressure				Cancer			
Heart disease				Mother living?			
				Father living?			

STUDENT'S MEDICAL HISTORY

Yes	No		Yes	No		Yes	No	
		Anemia (Including sickle cell anemia			Glaucoma			Kidney or bladder infection or stone
		Anorexia or bulimia			Hearing loss (complete or partial)			Migraine headache
		Asthma, wheezing			Heart enlargement			Polyps of colon
		Bleed disorder			Heart murmur			Rheumatic fever
		Blindness (complete or partial)			Heart valve problem			Thyroid disorder
		Cancer (incl. leukemia, Hodgkin's disease)			Hepatitis or jaundice			Tuberculosis
		Chickenpox			High blood pressure			Stomach ulcer
		Cystic fibrosis			Immunodeficiency disorder			Urinary tract infection
		Diabetes			Infectious mononucleosis			Other _____
		Epilepsy or other seizure disorder			Inflammatory bowel disease or Crohn's disease			Surgery _____

☐ Yes ☐ No **MEDICATIONS**: Check box to indicate whether you take any medications (including birth control pills, acne drugs, etc.) List medications, does, and reason for taking them (attach additional sheet if necessary).

Drug:_____ Dose:_____ Reason:_____

☐ Yes ☐ No **ALLERGIES**: Check box to indicate whether you have allergies. If so, specify type:
Medication (e.g., penicillin, sulfa drugs) (specify): _____

Environment (specify):_____ Food (specify): _____

☐ Yes ☐ No **INJURIES**: Check box to indicate whether you have had any serious accidents or injuries. If so, specify type (include details and dates)

Broken bones(s), fractures(s): _____

Concussion or other head injury: _____

Back, Hip, Knee, or ankle injury: _____

Other: _____

Yes No **MENTAL HEALTH**: Check boxes to indicate whether:

☐ ☐ You're academic and/or work activities have ever been interrupted because of mental or emotional problems.

☐ ☐ You have ever been under the care of a psychiatrist or mental health professional.

☐ ☐ You have ever been treated with any medication for psychiatric reasons. If so, provide details (medication, reason for taking it, dates, duration of treatment).

☐ ☐ You have ever been hospitalized for mental or emotional problems. If so, provide details (date, place, diagnosis, length of stay). _____

☐ ☐ You have ever had drug or alcohol dependency or addiction.

Yes No **WOMEN'S HEALTH:** Check boxes to indicate whether you have (or have had) any of these conditions. Provide details at right:

☐ ☐ Removal of breast lump or cyst/breast cancer Details:_____

☐ ☐ Evaluation for hormone problem _____

☐ ☐ Missed periods more than four months _____

☐ ☐ Excessive or extra periods _____

☐ ☐ Pregnancy _____

MEDICAL HISTORY TO BE COMPLETED BY STUDENT (Continued)

Confidential

Name of Student_____ Date of Birth_____ Hofstra ID #_____

Yes	No	
☐	☐	**WOMEN'S HEALTH CONT.:** Check boxes to indicate whether you have (or have had) any of these conditions. Provide details at right:
		Most recent Pap Smear: Date:_____ If abnormal, please provide details. _____
		MEN'S HEALTH: Check boxes to indicate whether you have (or have had) any of these conditions. Provide details at right:
☐	☐	Lump or mass in testicle Details:_____
☐	☐	Prostate infection _____

Respirator Medical Evaluation Questionnaire

To maintain confidentiality, please return this completed questionnaire in a sealed envelope or deliver it to the nearest Employee Health Service department. This questionnaire will be reviewed by a licensed health care professional.

PLEASE PRINT:

Date: Month: _____ Day: _____ Year: 20 _____

Your Name: (First)_____(Last) _____

Date of Birth____/____/____ Sex: Male___Female___ Ht:____’____” Wt:_____lbs.

Please include a phone number where you can be reached by the health care professional who reviews the questionnaire:

Home: ( )_____-_____Cell: ( )_____- _____

Job Title:_____Dept/Division:_____

If you are not sure of an answer below, you may leave it blank.

1. Check the type of respirator you will use (if applicable, you can check both “a” and “b”):

a. _____N, R, or P. disposable respirator (filter-mask, non-cartridge type only).

b. _____Other type (for example, half-or full facepiece type, powered air purifying, supplied air, self-contained breathing apparatus).

2. Have you worn a respirator (check one): Yes___No___If Yes, what type: _____

Please check Yes or No

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?

YES	NO

2. Have you had any of the following conditions:

	YES	NO
a. Seizures (fits)		
b. Diabetes (sugar disease)		
c. Allergic reactions that interfere with your breathing		
d. Claustrophobia (fear of closed-in places)		
e. Trouble smelling odors		

Name:_____DOB: _____

3. Have you ever had any of the following pulmonary or lung problems:

	YES	NO
a. Asbestosis		
b. Asthma		
c. Chronic Bronchitis		
d. Emphysema		
e. Pneumonia		
f. Tuberculosis		
g. Silicosis		
h. Pneumothorax (collapsed lung)		
i. Lung Cancer		
j. Broken ribs		
k. Any chest injuries or surgeries		
l. Any other lung problems that you've been told about		

4. Do you currently have any of the following symptoms of pulmonary or lung illness:

	YES	NO
a. Shortness of breath		
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline		
c. Shortness of breath when walking with other people at an ordinary pace on level ground		
d. Have to stop for breath when walking at your own pace on level ground		
e. Shortness of breath when washing or dressing yourself		
f. Shortness of breath that interferes with your job		
g. Coughing that produces phlegm (thick sputum)		
h. Coughing that wakes you early in the morning		
i. Coughing that occurs mostly when you are lying down		
j. Coughing up blood in the last month		
k. Wheezing		
l. Wheezing that interferes with your job		
m. Chest pain when you breathe deeply		
n. Any other symptoms that you think may be related to lung problems		

5. Have you ever had any of the following cardiovascular or heart problems:

	YES	NO
a. Heart attack		
b. Stroke		
c. Angina		
d. Heart Failure		
e. Swelling in your legs or feet (not caused by walking)		
f. Heart Arrhythmia (heart beating irregularly)		
g. High Blood Pressure		
h. Any other heart problem that you've been told about		

6. Have you ever had any of the following cardiovascular or heart symptoms:

	YES	NO
a. Frequent pain or tightness in your chest		
b. Pain or tightness in your chest during physical activity		
c. Pain or tightness in your chest that interferes with your job		
d. In the past two years, have you noticed your heart skipping or missing a beat		
e. Heartburn or indigestion that is not related to eating		
f. Any other symptoms that you think may be related to heart or circulation problems		

7. Do you currently take medication for any of the following:

	YES	NO
a. Breathing or lung problems		
b. Heart trouble		
c. Blood pressure		
d. Seizures (fits)		

8. If you have never used a respirator, check the following space:_____, and go to Question 10.

9. If you have used a respirator, have you ever had any of the following problems:

	YES	NO
a. Eye Irritation		
b. Skin allergies or rashes		
c. Anxiety		
d. General weakness or fatigue		
e. Any other problem that interferes with your use of a respirator		

10. Does your job function require the use of a respirator?

YES	NO

If you answered NO and your job function changes to require the use of a respirator, you will need to contact EHS for fit testing.

Mandatory Annual N95 Fit Testing is required:

- For all healthcare personnel who may provide care to patients with known or suspected aerosol transmissible diseases, i.e. tuberculosis (TB) (regardless of frequency)
- For all healthcare personnel whose job functions require entry into isolation rooms (regardless of frequency)

Occupational Safety and Health Administration (OSHA) requires fit testing to be conducted at least annually. Fit testing must also be conducted whenever you have a change in your physical condition that could affect the fit of the respirator. Such changes could include (but are not limited to):

- Large weight gain or loss
- Major dental work (such as new dentures)
- Facial surgery that may have changed the shape of your face; or significant scarring in the area of the seal

11. Would you like to talk to the health care professional, who will review the questionnaire, about your answers?

YES	NO

Employee Name (Print): _____

Employee Signature: _____ **Date:** _____

Respirator Medical Evaluation Questionnaire

First Name:_____Last Name:_____DOB:____/____/____

Dept/Div:_____Title/Position: _____

This form outlines the results of the Occupational Safety and Health Administration (OSHA) Respirator Medical Evaluation. If you have any questions regarding this evaluation please call Employee Health Services.

For Office Use Only

Based on the review of the OSHA Respirator Medical Evaluation Questionnaire this individual is:

____ Medically approved to be fit tested for a respirator, with the exception of Full-Facepiece Respirators or Self Contained Breathing Apparatuses.

____ Not approved to be fit tested for a respirator at this time. Follow-up medical evaluation is needed.

Date: _____

EHS Reviewer's Name (Print): _____

EHS Reviewer's Signature: _____

To Employee:

Please present this completed form to the Fit-Tester if you are approved to be fit tested

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Tuberculosis Screening Questionnaire

Name:_____ DOB: _____

Employee ID (if applicable): _____ Date: _____

Please circle Yes or No

1.) Do you have a history of positive Tuberculosis (TB) screening? **Yes** **No**

If yes, which test was positive?

D Tuberculin Skin Test (TST/PPD)
Month and Year of positive Test_____/_____
Size of induration? ☐ ☐ mm

D Blood based TB Screen (i.e. QuantiFERON-TB Gold; T-Spot.*TB*)
Month and Year of positive Test_____/____

2.) Were you born in the United States? **Yes** **No**

If no, what country were you born? _____
Year of immigration to the US? _____

3.) Have you received the BCG vaccine in the past? **Yes** **No**

4.) Have you ever taken or been advised to take medication for Tuberculosis because of a Positive TB Screening? **Yes** **No**

4a.) If medication was taken, please indicate what year it was taken and for how long.

Year:_____
Length:_____months

5.) Have you had a recent chest x-ray? **Yes** **No**

If yes, please attach results. (Must be within the last 12 months)

For individuals who have had a **Positive** reaction in the past to TST/PPD circle all that applies:

- Cough greater than 3 weeks Yes No
- Coughing up blood Yes No
- Loss of appetite Yes No
- Unexplained weight loss Yes No
- Night sweats Yes No
- Hoarseness Yes No
- Persistent Fever Yes No
- Weakness or fatigue Yes No
- Chest Pain Yes No

Signature_____ Date_____

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Students,

Use the attached Physical Examination form and Vaccination record if you plan on being screened by your own healthcare provider. To avoid delay, we highly recommend that you have the vaccination form completed or provide a copy of your vaccination record.

Confidential

Print Name _____ Hofstra ID # _____
Last First Middle

PHYSICIAN'S EXAMINATION

To the examining health care provider: Please correlate the student's medical history with your findings, and record below. All entries must be completed.

1. Sex _____ Height _____ Blood Pressure _____

Age _____ Weight _____ Pulse _____

2. Vision: Right 20/_____ Left 20/_____
With Correction: Right 20/_____ Left 20/_____
Hearing: Right_____/15 Left_____/15

Check each item in proper column. Enter "N.E." if not evaluated	**Normal**	**Abnormal**	**Note: Give Details of each abnormality. Enter corresponding item number before each comment**
3. Head, Neck, Face, and Scalp			
4. Nose and Sinuses			
5. Mouth, Teeth, Gingiva, and Throat			
6. Ears — General (Canals, Drums, etc.)			
7. Eyes — General (Lids, Pupils, Motions, etc.)			
8. Lungs, Chest, and Breasts			
9. Heart (include estimate of cardiac function)			
10. Vascular System (include varicosities)			
11. Abdomen and Viscera (include hernia)			
12. Anorectal and Pilonidal			
13. Endocrine System			
14. Genito-Urinary System			
15. Upper Extremities			
16. Lower Extremities (include feet)			
17. Spine, other Musculoskeletal			
18. Skin and Lymphatic (include acne)			
19. Neurological System			
20. Psychiatric			
21. If female, give menstrual history — specify if on medication.			
22. Urinalysis: Albumin Sugar Special tests used in clinical evaluation (Blood, EKG, X-ray, etc.):			
23. Does examinee need dental or eye care?			
24. Any medication allergies?			
25. Is this individual capable of normal physical activity (athletics, military training, physical education)? If not, give reasons and limitations.			

Comments: _____

Signature of health care provider is also required under Tuberculosis Screening on Page 5

Signature _____ Date of Examination _____

Please print, stamp or type name _____ Phone _____

Address _____

HOFSTRA UNIVERSITY

Name of Student:_____ Date of Birth:_____ Hofstra ID# _____

IMMUNIZATION RECORD

To be completed and signed by health care provider.

New York state law mandates this immunization record be on file prior to registration.

All information must be provided in English.

	MO/DAY/YR	MO/DAY/YR	MO/DAY/YR
*MMR (Measles, Mumps, Rubella) **(Two doses with live vaccine required of all persons born after 12/31/56.)** History of having measles or documentation of positive measles, mumps, rubella antibody titers			
OR *MEASLES (RUBEOLA) History of having measles, or **TWO immunizations with live measles vaccine after first birthday,** or documentation of measles antibody titer			
*MUMPS History of having mumps, or **immunization with live mumps vaccine after first birthday,** or documentation of mumps antibody titer			
*RUBELLA (German Measles) **History of having had rubella disease is NOT acceptable! Immunization with rubella vaccine,** or documentation of rubella antibody titer			
HEPATITIS B			
*Tdap (WITHIN 10 YEARS)			
POLIO (T.O.P.V.)			
MENINGOCOCCAL (one dose)			
*VARICELLA			

***required by New York State Department of Health and/or SON** (OTHERS STRONGLY RECOMMENDED).

I certify that the above-named student has received the immunizations listed above on the dates indicated.

Health Care Provider:_____ Phone No. _____
(PLEASE PRINT.)

Health Care Provider Signature:_____ Date: _____

Health Care Provider Stamp/Office Stamp for Address and Telephone Number: _____