Important Notice: COVID-19 vaccinations are required. Must provide a copy of CDC card with complete dosages. This form must be reviewed and signed by a healthcare provider.

Rockland County BOCES
Practical Nursing Program
Health and Immunization Record

Date _____ Date of Birth _____

Name _____
Last First Middle

Address _____
Street Apt #

City _____ State _____ Zip _____

Cell Phone # _____ Email _____

MEDICAL HISTORY: (Include present and past conditions)

_____

_____

_____

_____

_____

CURRENT STATUS:

			Right	Left
Height: _____	Lungs:_____	Hearing:	_____	_____
Weight:_____	Heart:_____	Vision:	_____	_____

B/P: _____

Other: _____

TUBERCULIN TEST:

PPD (must be within 1 year) Negative _____ Positive _____

Date _____

If Positive, Date of Chest X-Ray _____

Attach copy of CXR report. Must be within last 2 years.

ANTIBODY TITERS:

Record of Immunization not sufficient Titers required.
Attach copy of lab reports.

Rubella	Date _____	Level_____	Status _____
Rubeola	Date _____	Level_____	Status _____
Mumps	Date _____	Level_____	Status _____
Varicella	Date _____	Level_____	Status _____

VACCINATIONS:

Adult Diphtheria/Pertussis/Tetanus (within last 10 years) Date _____

HEPATITIS B

I have been vaccinated against Hepatitis B as shown below:

Date 1: _____ Date 2:_____ Date 3: _____

_____ I choose/have chosen not to receive the Hepatitis B series of vaccinations.

INFLUENZA VACCINE:

Attach documentation with the following information:

Date of immunization
Lot #
Health Care Provider Signature

CURRENT MEDICATIONS/TREATMENTS:

_____

_____

_____

HEALTHCARE PROVIDER RECOMMENDATION:

I have examined and determined that _____ is free from any health impairment of potential risk to self, patients or staff which might interfere with the performance of his/her duties, including, but not limited to the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter behavior. He/she can engage without restriction in clinical activities that may include bathing, turning, lifting, positioning, transferring to bed/chair and back to bed of conscious and unconscious patients and assisting unsteady patients with ambulation.

_____ _____
Signature of Health Care Provider Date

Stamp of Health Care Provider:

Name of Health Care Provider (please print): _____

Phone # _____

Address _____
_____