HELEN HAYES
HOSPITAL

Student Health Clearance

Name:____Date of Birth:____________________

REQUIRED/MANDATORY

I. MMR: (2) VACCINES REQUIRED **OR** **Measles Titer:**____________(Result and date)
_________________(Date) **Mumps Titer:**_____________(Result and date)
_________________(Date) **Rubella titer:**_____________(Result and date)

II. Varicella: (2) vaccines required **OR** **Varicella Titer:**_________________(Date)

_______________________(Date)

_______________________(Date)

OR

Physician documented history of chicken pox or zoster ___________________(Date)

III. Influenza Vaccine: ________________________(Date of **current season**)

IV. TST-Annual TB Skin Test Documentation of the results of 2 negative TST's both must be consecutive Years or a negative Quantiferon TB Gold test (QFT-G) with in the previous 12 months. (Attach results)

1.______________________________(Date) 2.______________________________(Date)
______________________________MM (Results) ______________________________MM (Results)

❑ Check box if documented history of positive TST.TST is waived and copy of chest x-ray report done within last five years is required. Date of CXR:_________________________Result:_____________________________

RECOMMENDED

Td/Tdap Booster:___________________________(Date)

Hepatitis B Vaccine: **#1.**_____________________(Date)
#2._____________________(Date)
#3._____________________(Date)

Name of Healthcare Provider:_____________________________________Date:____________________

Signature and License # of Healthcare Provider: _____________________________Date:____________________

Contractor Health Clearance (9/05/18)