HELEN HAYES HOSPITAL

# Student Health Clearance

**Name:** _____ **Date of Birth:** _____

## REQUIRED/MANDATORY

**I. MMR: (2) VACCINES REQUIRED**
_____ (Date)
_____ (Date)

**OR**

**Measles Titer:** _____ (Result and Date)
**Mumps Titer:** _____ (Result and Date)
**Rubella titer:** _____ (Result and Date)

_____

**II. Varicella: (2) vaccines required**
_____(Date)
_____(Date)

**OR**

**Varicella Titer:** _____ (Result and Date)

**OR**

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

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

**IV. COVID Vaccine #1:** _____ **(Date)** **#2:** _____ **(Date)**

**V. Documentation of two-step TST results and date or a negative Quantiferon TB Gold test (QFT-G). (Attach results)**

1._____ (Date)
_____ MM (Results)

2. _____ (Date)
_____ MM (Results)

☐ Check box if documented history of positive TST. TST is waived and copy of chest x-ray report done.
Date of CXR: _____ Result: _____
☐ Complete TB risk assessment and TB symptom assessment.

### TB Risk Assessment

1. Temporary or permanent residence (for ≥ 1 month) in a country with a high TB rate (i.e., any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe ❑ Yes ❑ No **OR**
2. Current or planned immunosuppression, including human immunodeficiency virus infection, receipt of and organ transplant, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥ 15 mg/day for ≥ 1 month), or other immunosuppressive medication ❑ Yes ❑ No **OR**
3. Close contact with someone who has had infectious TB disease since the last TB test ❑ Yes ❑ No

**TB SYMPTOM ASSESSMENT**

| | | | | | |
|---|---|---|---|---|---|
| Persistent fever | ❑ Yes | ❑ No | Unexplained weight loss | ❑ Yes | ❑ No |
| Night sweats | ❑ Yes | ❑ No | Fatigue | ❑ Yes | ❑ No |
| Cough lasting > 3 weeks | ❑ Yes | ❑ No | Hoarseness | ❑ Yes | ❑ No |
| Bloody sputnum | ❑ Yes | ❑ No | Chest pain | ❑ Yes | ❑ No |

Any other unusual symptoms _____

If history positive, were you ever treated? ❑ Yes ❑ No

HELEN HAYES HOSPITAL

# Student Health Clearance

**RECOMMENDED**

**Td/Tdap Booster:** _____ (Date)

**Hepatitis B Vaccine:**

**#1.**_____ (Date)

**#2.**_____ (Date)

**#3.**_____ (Date)

Name of Healthcare Provider: _____Date: _____

**Signature of Healthcare Provider*:** _____Date: _____

**License#*** : _____

**Required*