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)*

***Attach Serology Results**

II. Varicella: (2) vaccines required

_____(Date)

_____(Date)

OR

Varicella Titer: _____ (Result and Date)

OR

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

III. 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

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RECOMMENDED

Td/Tdap Booster: _____ (Date)

Hepatitis B Vaccine: **#1.**_____ (Date)

#2._____ (Date)

#3._____ (Date)

Influenza Vaccine: _____ (Date of current season)

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

Name of Healthcare Provider: _____Date: _____

Signature of Healthcare Provider*: _____Date: _____

License#* : _____

*Required