HELEN HAYES HOSPITAL

Student Health Clearance

Dates of Internship: _____ **to** _____

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)

***Attach Serology Results**

OR

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

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

1. _____ (Date)

_____ MM (Results)

2. _____ (Date)

_____ MM (Results)

OR Quantiferon TB Gold Test (Date): _____ ***Attach Results:** _____

❑ Check box if documented history of positive TST/Quantiferon TB Gold test. TB testing is waived and copy of chest x-ray report is required.

❑ Complete TB symptom assessment below.

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

continued on side 2

HELEN HAYES HOSPITAL

Student Health Clearance

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)**

Last COVID Booster: _____ **(Date)**

Name of Healthcare Provider: _____ **Date:** _____

Signature of Healthcare Provider*: _____ **Date:** _____

***License#**: _____

**Required*