DAEMEN CLINICAL HEALTH FORM (AMHERST CAMPUS)

STUDENT SUBMISSION TO: Upload our individual EXXAT APPROVE profile. Label each page as indicated below and submit it to respective compliance folder.

DAEMEN UNIVERSITY

PART 1 – RECORD OF IMMUNIZATIONS FOR VERIFICATION

Students may take this form to their medical provider to complete, sign or stamp. Alternatively, students may submit immunization and health records from a previous school, medical provider or government agency. All health records must be submitted in English.

Measles, Mumps, Rubella (MMR)

1. 2 Vaccinations: _____/_____/_____ _____/_____/_____
2. MMR – Positive Titer date: _____/_____/_____ If negative: booster date: ____/_____/_____

Hepatitis B (Choose one option below)

3. 3 Vaccinations: _____/_____/_____ _____/_____/_____ _____/_____/ _____
4. Hepatitis B – Positive Titer date: _____/_____/_____ If negative: booster dates: _____/_____/_____ and ____/_____/_____

Varicella (Chicken Pox) (Choose one of three options below)

1. 2 Vaccinations: _____/_____/_____ _____/_____/ _____
2. Disease Date: _____/_____/ _____
3. Varicella – Positive Titer date _____/_____/_____ if negative: booster date: ____/_____/_____

Tdap/TD – MUST BE COMPLETED WITHIN 10 YEARS OF CLINICAL EXPERIENCE START DATE (Choose one of two options below)

1. Tdap (tetanus, diphtheria, and pertussis) vaccination: _____/_____/ _____
2. TD (tetanus and diphtheria) vaccination (if applicable): _____/_____/ _____

Tuberculosis Screening – Between May 1 and May 10 each calendar year (Choose one of three options below)

1. Mantoux Tuberculin Skin Test: Test Date:_____/_____/_____ Read Date:_____/_____/_____ Result: _____
   2-step PPD: encouraged for PA students Test Date: _____/_____/_____ Read Date: _____/_____/_____ Result: _____
2. QuantiFERON TB Gold Blood Test: Test Date:_____/_____/_____ Result:_____(Attach lab report)
3. T-Spot Blood Test: Test Date:_____/_____/_____ Result:_____ (Attach lab report)

Influenza MUST BE COMPLETED EACH FLU SEASON

1. Vaccination date:_____/_____/ _____

Meningococcal (Dates of initial series and additional boosters)

1. Vaccination dates: _____/_____/_____ _____/_____/_____

All immunizations above verified by Health Care Provider: YES / NO

Comments if NO:

Provider Name (print or stamp) Provider Signature Provider Address & Phone Number Date

STUDENT INFORMATION:

LAST NAME FIRST NAME MIDDLE INITIAL DATE OF BIRTH ANTICIPATED GRADUATION

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PART 2 – PHYSICAL EVALUATION Must be completed within 1 year of starting clinical experiences and remain current (<1-year-old) for the duration of clinical experiences.

1. Date of physical examination:_____/_____ /_____
2. Clinical Experience Physical Evaluation (please attach documentation regarding concern(s) for participation, if applicable)
   a. Is this person free from communicable diseases that could jeopardize the health of others? Y: _____ N: _____
   b. Are there any restrictions of physical activity indicated by your examination? Y: _____ N: _____

Provider Name (print or stamp)	Provider Signature	Provider Address & Phone Number	Date

STUDENT INFORMATION:

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH	ANTICIPATED GRADUATION

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PART 3: 4 Panel Instant Drug Screen Students MUST have a negative drug screen within 1 month of starting clinical experiences

1. Date drug screening obtained: _____/_____/_____
2. Student received a completely negative drug screen: Y:____ N:____

Verified by:			
Name and Title	Signature	Address & Phone Number	Date

STUDENT INFORMATION:

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH	ANTICIPATED GRADUATION

STUDENT INFORMATION:

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH	ANTICIPATED GRADUATION