DAEMEN UNIVERSITY

Physician Assistant Program Student Health Form

Student Information

Last Name: _____ First Name: _____

Date of Birth: _____ Student ID: _____

Anticipated Graduation Year: _____

Part 1 is to be completed by the student. Please initial each section and sign below.

I am aware that the information provided on this form, including my immunization record, including titers (if needed), medical exemption documentation and related declination forms, and screening results are considered Personal Health Information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA).

With that knowledge, I **waive my right to confidentiality** regarding the above-named PHI for the limited purpose of releasing my immunization record, including titers (if needed), medical exemption documentation and related declination forms, and screening results to my designated program at Daemen University for the limited purpose of health compliance verification.

initial _____

I further **release my immunization and screening record,** including titers (if needed), medical exemption documentation and related declination forms, and screening results to clinical sites and/or preceptors upon request for the sole purpose of health compliance verification. initial _____

Student signature_____ Date: _____

Part 2 and Part 3 are to be completed by a healthcare provider.

Part 2 – Immunization Record

MMR (Measles, Mumps, Rubella)

☐ 2 Vaccinations Dates: _____ _____ or

☐ Positive Titer Date: _____ or

☐ Negative Titer – Booster Date: _____

Student Name: _____

Hepatitis B

☐ 3 Vaccinations Dates: _____ _____ _____ or

☐ Positive Titer Date: _____ or

☐ Negative Titer – Booster Dates: _____ _____

Varicella (Chickenpox)

☐ 2 Vaccinations Dates: _____ _____ or

☐ History of Disease Date: _____ or

☐ Positive Titer Date: _____ or

☐ Negative Titer – Booster Date: _____

Tdap/Td (within 10 years)

☐ Tdap Vaccination Date: _____ or

☐ Td Vaccination Date: _____

Tuberculosis Screening

- **Required prior to start of the professional phase of the program**
- **Must also be current for the duration of the clinical year (completed within the last 12 months)**

☐ 2-Step PPD (**Preferred**) Date: _____ Result: _____ Date:_____ Result:_____ or

☐ QuantiFERON Gold Date: _____ Result: _____ (attach lab) or

☐ T-Spot Date: _____ Result: _____ (attach lab) or

☐ CXR if Past Positive PPD Date: _____ Result: _____ (attach result)

Influenza (Current Season)

☐ Vaccination Date: _____

Meningococcal

☐ Initial Vaccination Series Dates: _____ _____

Student Name: _____

Part 3 – Physical Evaluation Screening

- **Required prior to start of the professional phase of the program**
- **Must also be current for the duration of the clinical year (completed within the last 12 months)**

Date of Physical Exam: _____

Is this student free from communicable disease(s) that could jeopardize the health of others? ☐ Yes ☐ No

Are there any physical restrictions indicated by the examination? ☐ Yes ☐ No

> If there are physical restrictions, the student will need to provide documentation to the Office of Accessibility Services at Daemen University. access@daemen.edu

Healthcare Provider Verification

Provider Name: _____

Signature: _____

Date: _____