DAEMEN COLLEGE CLINICAL HEALTH FORM

SUBMISSION OPTIONS: ONLINE: daemen.edu/healthupload | FAX: 716.839.8230
OFFICE: Wick 116, CHIP Center | MAIL: 4380 Main St. Box #104 Amherst, NY 14226

PART 1 – STUDENT INFORMATION

LAST NAME **FIRST NAME** **MIDDLE INITIAL** **DATE OF BIRTH** **PREFERRED PHONE (WITH AREA CODE)**

PROGRAM: ☐ AT ☐ PA ☐ PT ☐ NUR **CLINICAL SEMESTER(S):** ☐ SU ☐ FA ☐ SP ☐ 1 year (PA) **GRAD YEAR:** _____

PART 2 – RECORD OF IMMUNIZATIONS FOR VERIFICATION

Provider may fill out the form below or attach immunization dates, results and interpretations. ***ONLY DATES IN MM/DD/YY FORMAT ACCEPTED.***

Hepatitis B (Choose one of three options below)

1. 3 Vaccinations: _____ / _____ / _____ _____ / _____ / _____ _____ / _____ / _____
2. Hepatitis B – Positive Titer (attach lab report with date of titer, reading and interpretation of the result)
3. Complete Hepatitis B declination form (only permitted for clinical sites that accept declinations)

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

1. 2 Vaccinations: _____ / _____ / _____ _____ / _____ / _____
2. Disease Date: _____ / _____ / _____
3. Varicella – Positive Titer (attach lab report with date of titer, reading and interpretation of the result)

Tdap/TD – MUST BE COMPLETED WITHIN 10 YEARS (tetanus, diphtheria, and pertussis)/(tetanus and diphtheria)

1. Tdap vaccination: _____ / _____ / _____
2. TD vaccination (if applicable): _____ / _____ / _____

Tuberculosis PPD Test – MUST BE COMPLETED WITHIN 1 YEAR OF CLINICAL EXPERIENCE START DATE (Choose one of three options below)

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

Positive result for any of the aforementioned tests – Chest X-Ray Required (attach lab report)

Date of X-Ray: _____ / _____ / _____ Result: _____

If chest x-ray is/was positive, will/did the student complete treatment:

Y: _____ *(please attach documentation of treatment plan and note any restrictions)*
N: _____ *(please attach documentation of care plan to monitor condition)*

Flu Shot (Choose one of two options below)

1. Vaccination date: _____ / _____ / _____
2. Complete a flu declination form & wear a mask during clinical(s)

PART 3 – PHYSICAL EVALUATION

MUST BE COMPLETED WITHIN 1 YEAR OF CLINICAL EXPERIENCE START DATE
Student is encouraged to complete a medical history form from their provider's office prior to having an examination completed.

1. Date of physical Examination: _____ / _____ / _____
2. Clinical Experience Physical Evaluation
   (if there are concerns about student participation, please attach documentation regarding concern(s))
   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