

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 – REQUIRED RECORD OF IMMUNIZATIONS

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 two options below)

- 3 Vaccinations: ____ / ____ / ____ ____ / ____ / ____ ____ / ____ / ____
- Hepatitis B – Positive Titer (attach lab report with date of titer, reading and interpretation of the result)

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

- 2 Vaccinations: ____ / ____ / ____ ____ / ____ / ____
- Disease Date: ____ / ____ / ____
- 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)

- Tdap vaccination: ____ / ____ / ____
- TD vaccination (if applicable): ____ / ____ / ____

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

- Mantoux Tuberculin Skin Test: Test Date: ____ / ____ / ____ Read Date: ____ / ____ / ____ Result: _____
- QuantifERON TB Gold Blood Test: Test Date: ____ / ____ / ____ Result: _____ (Attach lab report)
- T-Spot Blood Test: Test Date: ____ / ____ / ____ Result: _____ (Attach lab report)

Positive Result – 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)

- Vaccination date: ____ / ____ / ____
- Complete a flu declination form & wear a mask during clinical(s) (form and masks housed in the Health Services Office – Wick 116)

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.

- Date of physical Examination: ____ / ____ / ____
- Clinical Experience Physical Evaluation
(if there are concerns about student participation, please attach documentation regarding concern(s))
 - Is this person free from communicable diseases that could jeopardize the health of others? Y: ____ N: ____
 - 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
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