

KEAN UNIVERSITY
School of Nursing
North Avenue Academic Building 3rd Floor
1000 Morris Avenue
Union, NJ 07083

ANNUAL HEALTH CLEARANCE FORM

DATE: _____

STUDENT NAME: _____

*Instructions: This form must be completed annually and must be signed by your Health Care Provider and uploaded to CastleBranch. Students will not be allowed to register for classes until all health clearance and immunization requirements are met. **NO EXCEPTIONS***

A. Immunization and Health Clearance Requirements

1. TUBERCULIN SCREENING

PPD STEP 1: Date given: _____ Date read: _____ Results (in mm): _____

PPD STEP 2: Date given: _____ Date read: _____ Results (in mm): _____

OR

QuantiFERON-TB Gold (QFT-G) may be substituted for PPD in individuals for whom PPD is contraindicated (attach laboratory results).

If PPD is positive by history or recent testing ($\geq 10\text{mm}$), attach copy of CXR and documentation of decision to administer or withhold anti-tubercular agents.

3. VACCINATIONS

Flu: Date given: _____

B. HEALTHCARE PROVIDER CERTIFICATION

I certify the above individual is in good health, has no limits on physical activity and is free of contagious diseases.

Health Care Provider

Signature

Date