KEAN UNIVERSITY

School of Nursing

North Avenue Academic Building 3rd Floor
1000 Morris Avenue
Union, NJ 07083

INITIAL HEALTH CLEARANCE FORM

DATE: _____

STUDENT NAME: _____

Instructions: This form must be completed by your Health Care Provider and uploaded to CastleBranch. Students will not be allowed to enroll in the program 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 (≥ 10mm), attach copy of CXR and documentation of decision to administer or withhold anti-tubercular agents.

2. IMMUNIZATIONS

Measles: ☐ Immune

Mumps: ☐ Immune

Rubella: ☐ Immune

Varicella: ☐ Immune

Hepatitis B: ☐ Immune

Equivocal results are not accepted. Revaccination is required if results are equivocal or negative, in accordance with CDC Healthcare Personnel Vaccination Recommendations (available at https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/a/healthcare-rec.pdf). Students requiring revaccination will require follow-up titers.

3. VACCINATIONS

Hepatitis B #1: Date given: _____ **Hepatitis B #2:** Date given: _____ **Hepatitis B #3:** Date given: _____

Tdap (must be within the last 10 years): Date given: _____

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

Revised: November 2017