Sacred Heart UNIVERSITY
ST. VINCENT'S COLLEGE

Student Name: ________________________________

Health Clearance/Physical Form

Please give this form to your healthcare provider at the time of your physical. Once completed, upload **ALL 3 PAGES** to your CastleBranch account **AND** to your Sacred Heart University Student Health Portal on the following website:
https://myhealth.sacredheart.edu/login_directory.aspx

(Health Care Provider - please complete pages 1 & 2 - Student to complete page 3)

Semester beginning school: Fall____ Spring ________

1	**MMR**			**One Time**
		Vaccine & Date Given	**Requirements**	**OR Titer (Lab results report required)**
	1	Measles #1 ☐ OR MMR ☐ Date:	1st immunization must be given on or after 1st birthday	
		Measles #2 ☐ OR MMR ☐ Date:	Must be at least 28 days after 1st immunization	Measles Titer (Lab results report required) Date:
				Results ☐ Positive ☐ Negative
	2	Mumps #1 ☐ OR MMR ☐ Date:	1st immunization must be given on or after 1st birthday	
		Mumps #2 ☐ OR MMR ☐ Date:	Must be at least 28 days after 1st immunization	Mumps Titer (Lab results report required) Date:
				Results ☐ Positive ☐ Negative
	3	Rubella #1 ☐ OR MMR ☐ Date:	1st immunization must be given on or after 1st birthday	
		Rubella #2 ☐ OR MMR ☐ Date:	Must be at least 28 days after 1st immunization	Rubella Titer (Lab results report required) Date:
				Results ☐ Positive ☐ Negative
2	**Varicella (Please Note That History of Chicken Pox Alone Will Not Be Accepted) First immunization must be given on or after 1st birthday**			**One Time**
		Varicella #1 ☐ **OR** Date:	Varicella Titer (Lab results report required) Date:	
		Varicella #2 ☐ Date:		
				Results ☐ Positive ☐ Negative
3	**Hepatitis B - 3 doses AND a Titer are required (lab results report is required)**			**One Time**
	1st dose date:	2nd dose date:	3rd dose date:	
	Hep Bsab (Quantitative) >10 = immune Date:		Results ☐ Positive ☐ Negative (attach lab results – hand written results will not be accepted)	
4	**Tuberculosis**			**Every year**
	Tuberculin skin test (Mantoux only) **Two step is only required for the first year**			
	A	PPD Step 1 Date Planted: PPD Step 2 Date Planted:	Step 1 Date Read: Results: ☐ Positive ☐ Negative Step 2 Date Read: Results: ☐ Positive ☐ Negative	**Provider's Initials:**
	B	PPD Step 2 Positive: **Radiology Report is Required for Chest x-ray, please attach**	Chest X-Ray Date:	
	If the PPD is positive, or the student has a previous history of a positive tuberculin skin test, a chest x-ray with normal findings, completed within the last 12 months, is required unless a history of INH therapy is documented. Repeat chest x-rays are not needed unless the student displays symptoms or signs of TB. The health care provider performing the annual physical should screen for signs and symptoms of TB.			

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<table>
<tr><td rowspan="3">5</td><td>Tdap</td><td>Every ten years</td></tr>
<tr><td colspan="2">Tetanus Diphtheria and Acellular Pertussis (TDAP): One dose of Tdap vaccine is required within the last ten years. Td boosters every 10 years thereafter.</td></tr>
<tr><td colspan="2">Tdap Date (within last 10 years):</td></tr>
<tr><td rowspan="2">6</td><td>Influenza Vaccine - Due by October 15th (Must be for current year's flu season)</td><td>Every year</td></tr>
<tr><td colspan="2">Influenza Vaccination Date:</td></tr>
<tr><td rowspan="3">7</td><td>Physical Exam Clearance</td><td>Every year</td></tr>
<tr><td colspan="2">All students must have a physical exam every 12 months. Your healthcare provider should complete this physical exam form, sign/stamp it and date it in the appropriate section. An unsigned or undated form will be rejected.</td></tr>
<tr><td colspan="2">Healthcare Provider Acknowledgement:

I acknowledge that I have completed the above required immunization/immunity testing and physical exam on the student named above.

On the basis of my health assessment and physical exam, this student is cleared to participate in all activities, including clinical assignments in a health care setting, with no restrictions and has no known allergies.

(Please Check) ☐ YES ☐ NO **Please indicate any known allergies and/or restrictions/limitations below:

Restrictions/Limitations (if any): ______________________________
____
____
____
____

Allergies & Type of Reaction (if any): ______________________________
____
____

Health Care Provider's Name: ______________________________

Address: ______________________________ Phone: ____________________

______________________________ Date Signed: ____________________
Healthcare Provider's Signature</td></tr>
</table>

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#	Requirement	Frequency
8	**CPR Certification – Basic Life Support (BLS)** All students must have a current CPR Certification. Only two types are accepted: **American Heart Association – Healthcare professional CPR Basic Life Support (BLS Provider),** OR **American Red Cross - Basic Life Support for Healthcare Providers**. Upload the front and back of your CPR Card to your CastleBranch account.	**Must remain current**
9	**Background Check – Ordered through CastleBranch** All students must have at least one background check, which is ordered through CastleBranch upon creation of your account. Subsequent background checks may be required depending on the contract provisions of your clinical placement site.	**One Time**
10	**Drug Testing – Ordered through CastleBranch** All students need to complete an annual drug test. Your initial drug test will be ordered through CastleBranch upon creation of your account. Instructions on completing the drug test will be located in your TO-DO-LIST of your CastleBranch account. If the student is starting in the Fall Semester, the drug test needs to be completed by July 15th. If the student is starting in the Spring Semester, the drug test needs to be completed by January 4th. If the student's clinical site requires additional testing, students must comply. Instructions for your subsequent drug tests will be sent to you at the end of the semester prior to the repeat being required.	**Every year**
11	**Student Statement of Responsibility Section** All students must submit a Statement of Responsibility every year	**Every year**

Student Statement & Release

I understand that I must complete all requirements noted on this form, in addition to any other requirements of my clinical site, prior to participation in any clinical experience. **Initial Here**: _____

I am aware that if my health status changes in any way that would impact my ability to perform in any of the Programs at St. Vincent's College, I must notify the appropriate Program Director as soon as possible. I understand the need for additional clearance will be determined at that time. **Initial Here:** ____

I hereby certify that the information provided in this form is true and accurate to the best of my knowledge and abilities, and I willingly release it to St. Vincent's College and their contracted partners, to be used solely in regards to my education and clinical placement through the College. This information will not be disseminated for any other purpose than that specified by myself, the applicant. By affixing my signature, I grant my full consent for release for the duration of my enrollment at St. Vincent's College. I am aware that I can revoke this consent, in writing, at any time. **Initial Here**: _____

Student Name (Print)__________________________________Date __________________________

Student Signature_____________________________________Student ID ______________________