PRE-CLINICAL HEALTH CLEARANCE

Nursing Students

All items must be completed and returned to the Director of Health Services by September 1st. Students must have clinical clearance to participate in lab/clinical activities.

(PRINT CLEARLY)

Bloomfield College
Heath Services Office
(973)259-3020 x1360
FAX# (973) 259-0413
Drop Off Address:
198 Liberty St. 2nd FL.
Bloomfield, NJ 07003

LAST NAME _____ **FIRST NAME**_____ **ID#** _____

CELL PHONE _____ **HOME PHONE** _____**LAST 4 DIGITS OF SS#**_____

DATE OF BIRTH _____ **AGE** _____ **E-MAIL** _____

ADDRESS _____

VITAL SIGNS:		
BP	**HEIGHT**	**VISION**
PULSE	**WEIGHT**	**CORRECTED VISION:**
HEARING	**Allergies:**	**Latex Allergy:**

HISTORY:

List significant past injuries and health problems:

_____

List past surgeries:

_____

List current medications and purpose:

PHYSICAL	**NORMAL FINDINGS**	**ABNORMAL FINDINGS/COMMENTS**
Neuro		
Head & Neck		
Abdominal		
Respiratory		
Cardiac		
Musculoskeletal		
Integumentary		
Other		

TB (Mantoux) Testing /Two Step (given between 1 week and 12 months apart)	**Students with a history of BCG vaccination are not exempt from TB testing. All positive reactions are considered infected with TB and must be treated accordingly. See instruction**	
Step 1 Date _____	Results _____MM	If 0-9 mm induration repeat test in 1-3 weeks
Step 2 Date _____	Results _____ MM	**YEARLY THEREAFTER**
Chest X-ray report if > 10mm **Treatment Plan: (Required for (+) Test)**	☐ _____ **months of INH Prophylaxis completed** ☐ **Other treatment plan** _____	

Revised 5/09

LABORATORY WORK (SUBMIT COPIES OF LAB FINDINGS)	
CBC	
CCA 18 (comprehensive metabolic panel)	
Urinalysis	

Rubella titer - Submit Report	If Rubella non-immune Give one dose _____ **REPEAT TITER IN 60 DAYS**
Rubeola titer - Submit Report	If Rubeola non-immune or Equivocal-two doses given at least 30 days apart are required. First dose _____ Second dose _____ **REPEAT TITER IN 60 DAYS**
Mumps titer -Submit Report	If mumps non-immune give one dose _____ **REPEAT TITER IN 60 DAYS**
Varicella titer - Submit Report	If Varicella negative or equivical: Give two doses First dose _____ Second dose _____ **REPEAT TITER IN 60 DAYS**
Hepatitis B Vaccine First Dose _____ Second Dose _____ Third Dose _____ **AND** ___ Positive Hepatitis B Surface Antibody Lab Report (60 days after last dose of vaccine)	
Tdap Date _____ (within the past 2 years)	**Influenza Vaccine _____**

Healthcare Provider Stamp (INCLUDES NAME, DEGREE, ADDRESS & PHONE NUMBER)	Based upon a physical examination and the above indicated test results, I am of the opinion that this student is in good health. **Exam Date: _____** _____ **Signature of Healthcare provider:MD,DO,NP only**

I have been given the opportunity to discuss the occupational risks of nursing with the Division of Nursing and the Director of Health Services. I understand these risks and wish to be enrolled in the nursing major at Bloomfield College.

_____ _____

Date **Student Signature**