Health and Safety Documentation Form

Name: _____ Date:_____

Use this worksheet as a guide to ensure that you have documentation of each requirement.

☐ **MMR (Measles/Rubeola, Mumps and Rubella)** To meet requirement:
1. MMR vaccination: Dates: #1_____ #2_____
OR
2. Date & IgG titer results: (please note negative or equivocal results are not accepted)
Measles: _____ _____
Mumps: _____ _____
Rubella: _____ _____

☐ **Varicella (Chickenpox)** To meet requirement: (History of disease is NOT sufficient)
1. Varicella vaccination dates: #1_____ #2_____
OR
2. Date & results of varicella IgG titer: (please note negative or equivocal results are not accepted)
Date: _____ Result: _____

☐ **Tetanus/Diphtheria/Pertussis (Tdap)** To meet requirement:
Proof of a one-time Tdap vaccination and Td booster if 10 years or more since Tdap vaccination
Tdap vaccine: Date: _____
Td booster: Date: _____

☐ **Tuberculosis** To meet requirement:
1. Negative 2-step TB Skin Test (TBST) within the previous 6 months, including date of administration, date read, result, and name and signature of healthcare provider.
Initial Test (#1) Date: _____ Date Read: _____ Results: Negative or Positive
Boosted Test (#2) Date: _____ Date Read: _____ Results: Negative or Positive
*The Boosted Test is 1-3 weeks after the initial test
2. Annual 1-step TBST (accepted only for students who also submit initial 2-step TBST)
Date: _____ Date Read: _____ Results: Negative or Positive
OR
3. Negative blood test (Either QuantiFERON or TSpot) within the previous 6 months
QuantiFERON Date: _____ T-Spot Date:_____
OR
4. Negative chest X-ray: Date: _____

☐ **Hepatitis B** To meet requirement:
1. Positive anti-Hbs or HbsAb titer Date: _____ Result: _____
OR
2. Proof of 3 Hepatitis B vaccinations
Hepatitis B vaccine/dates: #1_____ #2_____ #3_____
OR
3. Hepatitis B declination- students who choose to decline Hepatitis B vaccine series must submit a HBV Vaccination Declination form.

☐ **CPR Card (Healthcare Provider level)** To meet requirement:
CPR card or certificate showing date card issued: _____ Expiration date: _____

☐ **Level One Fingerprint Clearance Card (FCC)** To meet requirement:
Level One FCC including date card issued: _____ Expiration date: _____

☐ **Health Care Provider Signature Form** To meet requirement:
Form signed and dated by healthcare provider within the previous 6 months. Date of exam: _____

Health Care Provider Signature Form

Clearance for Participation in Clinical Practice

It is essential that allied health students be able to perform a number of physical activities in the clinical portion of their programs. At a minimum, students will be required to lift patients and/or equipment, stand for several hours at a time and perform bending activities. Students who have a chronic illness or condition must be maintained on current treatment and be able to implement their assigned responsibilities. The clinical allied health experience also places students under considerable mental and emotional stress as they undertake responsibilities and duties impacting patients' lives. Students must be able to demonstrate rational and appropriate behavior under stressful conditions.

I believe the applicant_____WILL OR_____WILL NOT be able to function as an allied health student as described above.

If not, explain: _____

_____

_____

Licensed Healthcare Provider (MD, DO, NP, or PA) Verification of Health and Safety

Print Name:_____ Title: _____

Signature:_____ Date: _____

Address: _____

City:_____ State: _____

Telephone: _____