New Jersey City University
College of Professional Studies
Nursing Department

HEALTH CLEARANCE FORM

Name:_____

Instructions: This form must be completed by the Health Care Provider *in addition* to the NJCU Student Health Record. Submit this document to the Nursing Department once all items are completed.

TUBERCULIN SCREENING

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

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

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

If PPD positive by history or recent testing (≥ 10mm), attach copy of CXR and documentation of decision to administer or withhold anti-tubercular agents.

TITERS (Laboratory results must be attached – Proof of vaccination does not meet requirements)

Measles: ☐ Immune ☐ Not Immune (requires vaccination)

Mumps: ☐ Immune ☐ Not Immune (requires vaccination)

Rubella: ☐ Immune ☐ Not Immune (requires vaccination)

Varicella: ☐ Immune ☐ Not Immune (requires vaccination)

Hepatitis B: ☐ Immune ☐ Not Immune (requires vaccination)

Equivocal results are not accepted*. Revaccination is required if results are equivocal or negative, in accordance with CDC Healthcare Personnel Vaccination Recommendations (available at http://www.immunize.org/catg.d/p2017.pdf). Students requiring revaccination will require follow-up titers.*

VACCINATIONS

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

Hepatitis B #3: Date given:_____ Tdap: Date given:_____

Other (please specify):_____ Date given:_____

HEALTHCARE PROVER 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 February, 2014