INITIAL CLINICAL HEALTH CLEARANCE GUIDE

Pre-entrance and periodic health evaluations are required by all students in the nursing major going to a clinical setting. This required data meets the requirements of the state of New Jersey Department of Health, as well as the various clinical agencies in which students affiliate. Carefully review the requirements below to successfully complete the attached Health Clearance Packet in its entirety. ***Students who do not complete the clearance by the first day of the semester must drop all clinical classes and resume the following semester on a seat availability basis.***

Initial Health Clearance Requirements:

☐ **1. Initial Physical Exam for Clinical Clearance** form completed (front and back pages): Student must have a physical exam performed by a healthcare provider within 1 year of clinical start date. All information must be completed, including vision/color screen, date of physical exam, signed and stamped by the healthcare provider.

☐ **2. Two-Step PPD (Mantoux) OR QuantiFERON-TB Gold/ T-SPOT (blood test**) within 3 months of clinical start date**:**

- **a.** Student must have a Two-Step PPD (second PPD administered 1 to 3 weeks after first PPD) or documentation of annual TB tests within the previous *three years.*
  - **i.** The following **must** be included to be a valid: the dates of the PPD placement, the dates the test was read, negative or positive result, and induration size in mm.

  OR

- **b.** QuantiFERON-TB Gold/T-SPOT blood test performed: must submit a copy of the lab report.

- **A positive PPD or positive QuantiFERON-TB/T-SPOT test: Action Required**
  Please submit a post-positive chest x-ray report. Documentation of (prophylactic) medication regimen by a healthcare provider required and yearly documentation of TB symptoms check.

☐ **3. Complete blood count (CBC) lab report** within 1 year of clinical start date.

☐ **4. Varicella (Chickenpox):**

- **a. IgG titer (laboratory blood test for antibodies):** must submit a copy of the lab report regardless of past history of disease or vaccination.

- **For Negative Varicella Titer: Action Required:**
  If there is documented history of 2-dose Varicella vaccinations, then *1 dose of Varicella booster vaccine is required.* If there is no documented vaccination history, then 2 dose Varicella vaccination is required: second dose at least 28 days after the first dose. Please submit vaccination record, if not done so already.

- **For Equivocal Varicella Titer**:
  If there is documented history of 2-dose Varicella vaccination, then a booster is *highly recommended* but not required. If the student has only received 1 dose of the vaccine in the past then a *second dose of the vaccine is required.*

☐ **5. Measles, Mumps, and Rubella (MMR):**

- a. **IgG titer (laboratory blood test for antibodies):** must submit a copy of the lab report with each results.

- **For Negative Measles, Mumps, or Rubella Titer Results: Action Required:**
  If there is documented history of 2-dose MMR vaccinations, then *1 dose of MMR booster vaccine is required.* If there is no documented vaccination history, then 2 dose MMR vaccination is required:

second dose at least 28 days after the first dose. Please submit vaccination record, if not done so already.

- **<u>For Equivocal Measles, Mumps, or Rubella Titers</u>**:
  If there is documented history of 2-dose MMR vaccination, then a booster is *highly recommended* but not required. If the student has only received 1 dose of MMR vaccine in the past then a *second dose of the vaccine is required.*

☐ **6. Hepatitis B**

a. Documentation of a 3-dose series of Hepatitis B vaccine.
<u>OR</u>

b. Documentation of **<u>positive Hepatitis B Surface Antibody test</u>**: must submit a copy of the lab report.

- **<u>For Negative Hepatitis B Surface Antibody: Action Required</u>**
  If there is documented history of 3-dose Hepatitis B vaccinations, then *1 dose of Hepatitis B booster vaccine is required.* If there is no documented vaccination history, then 3-dose Hepatitis B vaccination is required at 0, 1, and 6-month intervals.

☐ **7. Tetanus/Diptheria/Pertussis Vaccine (Tdap/Td)**

a. Documentation with date of vaccination of Tdap vaccine in a lifetime and Td booster every 10 years. If no documentation of Tdap is presented a single dose of Tdap is required.

☐ **8. Flu vaccine**

a. Documentation of annual flu vaccine during the flu season (August through May).

☐ **9. Clinical Student Request and Authorization to Release Records and/or Information Form:** must be signed and dated annually.

☐ **10. Urine Drug Screen** through Castle Branch. Please follow specific instructions as instructed by the Nursing Dept.

Students may select to have the clinical clearance physical exam and required tests done by private health care provider or at WPU Counseling, Health and Wellness Center (CHWC). CHWC also provides 2-step PPD, Tdap, and Flu vaccination for a minimal fee. Please call CHWC for pricing and to schedule an appointment as earliest possible at (973) 720-2360.

Please submit **<u>ALL</u>** completed forms and documents to the CHWC. ***Incomplete packets will <u>not</u> be accepted and will cause a delay in your clearance.*** You may submit in person (drop off documents at the front desk or schedule appointment with nurse to review in person- *highly recommend*). You may also submit by fax (may subject to delay). When all clearance requirements are met, the CHWC will document clearance date electronically and students may access WPUconnect to see their nursing clearance.

William Paterson University
Counseling, Health and Wellness Center
Overlook South
300 Pompton Road
Wayne, NJ 07470
(973) 720-2360 (for appointments)
(973) 720-2632 (fax)

William Paterson University

Physical Exam for *Initial* Clinical Clearance- Page 1

For *Nursing or Communication Disorder Majors only*

INCOMPLETE FORMS/DOCUMENTS WILL NOT BE ACCEPTED

Submit completed forms and all required documents only to:

Counseling, Health & Wellness Center - Overlook South - 300 Pompton Road – Wayne, NJ 07470

*For appointments/questions call: (973) 720-2360 * Fax (973) 720-2632*

Patient Name: ____ **DOB:** ______________

Student ID#: 855_____________________ **Contact Phone#** _______________________

Program *(circle one):* Nursing Graduate Nursing DNP Communication Disorders

Allergies *(specify reaction)*: _________________________ **Current Medications**: _________________________

Past Medical History: ____

1. Physical Examination ***(To be filled out by a medical provider)*** **LMP** ________

HT ________ **WT** ________ **BP** __________ **HR** ________ **RR** ________ **TEMP**________

Vision Screen-mandatory: Left Eye _____/_____ Right Eye_____/_____ *Circle One:* With /Without Correction

Color testing *(circle one):* Pass Fail

	WNL	Abnormal/Comments
General		
Skin		
Nodes		
HEENT		
Mouth		
Chest/Breast		
Lungs		
Heart		
Abdomen		
Gent/Rect		
Extremities/Hips		
Back/Spine		
Musculoskeletal		
Neuro		

2. Assessment:

Patient is medically cleared to participate in the clinical setting ***(please circle one):*** **Yes No**

If no, explain reason: ____

____ ______________

Provider Name & Signature **Date**

Provider's Stamp (Required)

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Physical Exam for *Initial* Clinical Clearance- Page 2

(All the information below is to be filled out by a medical provider and stamped at the bottom)

Patient Name: ____ **DOB:** ________________

3. Tuberculosis Screening *(via blood test **-OR-** PPD):*

Option #1: Provide a copy of QuantiFERON TB-Gold –or- T-SPOT lab test results within the last 3 months ☐

-OR-

Option #2: 2-step PPD:

1st-step: Date Placed: ___________ Date Read: ___________ Result: ________mm Negative Positive

If 1st-step is negative, repeat 2nd-step, 1-3 weeks after initial (1st) test

2nd-step: Date Placed: ___________ Date Read: ___________ Result: ________mm Negative Positive

If valid 2-step PPD was completed > 10 months ago, patient needs 1 updated PPD now:

Annual PPD: Date Placed: ___________ Date Read: __________ Result: ________mm Negative Positive

Positive results complete all information below:

Interpretation of Mantoux according to "at risk" status of individual tested, i.e.: > 5mm, 10mm,15mm may require follow up (June 2000, CDC guidelines):

CXR Date(s): ________________________________ **Results**: Negative Positive ______________________________

TB Symptoms Assessment (date & results): ____

Prophylaxis/Treatment History *(Include date started and end date):* ______________________________________

Precautions and follow-up instructions: ____

If treatment is not recommended, give reason: ____

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4. CBC: Provide copy of complete blood count lab report completed within 1 year of clinical start date ☐

5. ****VARICELLA* **& Measles, Mumps, Rubella titers: Provide copy of the titer lab results, not the vaccine dates ☐

**Non-immune* titer results *require* a booster **Equivocal* titer results, booster *recommended*

MMR Booster Date *(if applicable)* _______________ Varicella Booster Date *(if applicable)* ______________

6. Hepatitis B Vaccine: Dates of Immunizations *(or attach authorized copy of vaccines)*

Dose #1 _______________ Dose #2 _________________ *2-dose series?* ☐ Dose #3 ______________

- OR - *Optional only if Hep B vaccine records are not available:*

Provide copy of positive Hepatitis B Surface Antibody test result ☐

7. Tdap* Vaccine: *(tetanus, diphtheria & pertussis)* within the last 10 years. Vaccine Date: _______________

8. Flu* Vaccine: *annually during current flu season* Vaccine Date: ______________

**PPD testing, Tdap and Flu vaccines are available at The Counseling, Health & Wellness Center – Please inquire about cost. Call for an appointment & look out for our advertisements for Flu clinics in the fall*

Provider's Stamp (Required)

Revised 1/16/19

William Paterson University
Clinical Student Request and Authorization to Release Records and/or Information

This form when completed and signed by you authorizes the Counseling, Health and Wellness Center, the Directors & Clinical Instructors of the Nursing Department, and the Directors & Clinical Instructors of the Communication Disorders Program to release protected information from your clinical record to the person or agency you designate.

I, ____, authorize the Counseling, Health and
(Print name of student)

Wellness Center clinical and administrative staff, the Directors & Clinical Instructors of the Nursing Department, and the Directors & Clinical Instructors of the Communication Disorders Program to release information to one another regarding my clinical physical and any relevant information related to participation in the nursing and communication disorders programs at William Paterson University.

The records are to be discussed verbally, via fax, or via email for the purpose of coordination of care. This authorization shall remain in effect for one year from the date signed below (unless otherwise indicated).

I understand that I have the right to revoke this authorization in writing, at any time by sending or delivering such written notification to the Counseling, Health and Wellness Center. However, my revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

________________________________ ____________________

Student ID# Date of Birth

____ ________________

Signature of student (*parent if minor)* Date

Revised 1/11/15