William Paterson University
Re-Clearance Form for Clinical Participation

To be filled out by the student and returned to the Health Center for re-clearance only
If you have never been cleared by the health center before, you need an initial clearance form

**Prices subject to change**
Updated 8/18/16

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

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Since your last clinical clearance (*please circle yes or no and explain if applicable)*:

1. Have you had any changes in your general health?  NO  YES

   If yes, explain: ___________________________________________________________

2. Have you been diagnosed with an illness?  NO  YES

   If yes, please explain: ____________________________________________________

3. Have you had any injuries/surgeries/procedures?  NO  YES

   If yes, please explain: ____________________________________________________

4. Have you started any medications (prescribed or OTC)?  NO  YES

   If yes, list medication, dosage, frequency & reason for use:
   ________________________________________________________________________

5. Have you had any known exposure to any communicable diseases including tuberculosis?  NO  YES

   If yes, explain: __________________________________________________________

6. **Tuberculosis Screen:** Provide records for any **ONE** of the following:
   - Annual Single step PPD/Mantoux test - *(PPD available at CH&WC with an appointment for $5*)
   - Annual QuantiFERON TB-Gold test – *(provide lab report)*
   - Annual T-SPOT test - *(provide lab report)*
   - If you had any positive test results in the past, then you need to schedule an appointment with CH&WC for a follow-up -OR- provide clearance note from your provider that you are cleared for clinical

7. **Tdap Vaccine:** If not already submitted, provide documentation of vaccine **within** the last 10 years *(Tdap vaccine is available at CH&WC for $45*)

8. **Flu Vaccine:** Provide record of vaccine for current/upcoming flu season *(can be submitted to nursing dept.)*

9. Complete **Clinical Student Request and Authorization to Release Records and/or Information** Form

10. Please sign & date: **To the best of my knowledge, the above information is accurate**

   ________________________________________________             ______________
   **Student’s Signature**                           **Date**

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DO NOT SIGN BELOW THIS LINE – FOR CH&WC STAFF ONLY

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Reviewed by Health & Wellness Center Staff (Sign & Print Name)             Date

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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 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.

_________________________________     _______________
Signature of student (parent if minor)    Date