GRIFFIN HOSPITAL
SCHOOL OF ALLIED HEALTH CAREERS

Medical Office Building
300 Seymour Ave
Ste. 201A Derby, CT 06418-1343
P: (203) 732-7147
F: (203) 734-1132
PNProgram@griffinhealth.org

Practical Nursing Program Student Health Form

Instructions

- All students are required to have a completed health form on file to be able to participate in classroom and clinical experiences.
- Forms must be submitted to the Allied Health Coordinator at least **two weeks prior to the start of classes**.
- Completed forms can be submitted in person or via fax, email or mail.
- Should a student's health status change in such a way that it impacts their ability to meet the requirements of the nursing program, the student must promptly notify the Program Director.
- Student checklist:

Physical Exam
- Must be completed on School of Allied Health Physical Exam Form (page 2) by provider

COVID-19
- Documentation of completed primary vaccine series ***and*** booster

Hepatitis B
- positive HBsAb titer required; proof of vaccination alone not sufficient

Influenza
- Date of annual vaccine
- Must receive annually

MMR
- positive IgG titer required; proof of vaccination alone not sufficient

Tdap
- current tetanus, diphtheria, acellular vaccine within 10 years

Tuberculosis
- IGRA (QuantiFERON) ***preferred*** or two-step TB skin test
- If either test is positive, chest X-ray is required

Varicella
- Dates of vaccination (28 days apart) ***or***
- positive IgG titer

Student Acknowledgement

By signing below I, _____, acknowledge the following:

- A completed health form including documentation of immunization status and associated blood work must be completed before I can participate in class or clinical experiences.
- If my health status should change while I am a student in the practical nursing program, I must notify the program director to determine if additional clearance is needed.

Signature:_____ **Date:**_____

Name (printed):_____

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Student Information:

Name: _____ **DOB** _____
Last First M.I. *MM/DD/YY*

Address: _____
Street *Apt/Unit #*

_____
City *State* *Zip Code*

Contact: _____
Phone *e-mail*

Emergency Contact: _____
Name *Relationship to Student*

_____
Phone

Physical Exam Form – All Fields Required (*This section to be completed by health care provider*)

Date of Exam:_____

Allergies:

Does the student report or have a history of a latex allergy? ☐ Yes ☐ No

Does the student report or have a history of any other allergies? ☐ Yes ☐ No

If yes, please specify:_____

Does the student carry an Epi-pen? ☐ Yes ☐ No

Clearance for N95 Fit Testing (*per OSHA guidelines, N95 fit testing requires medical clearance*) ☐ **Yes** ☐ **No**

Student is medically cleared to be fitted for an N95 or other respirator & to wear it while caring for patients. The Griffin Hospital School of Allied Health Careers will arrange fit testing if needed for program of study.

Attestation of Student's Ability to Participate in Clinical Experiences

Per my physical exam and review of health history, it is my opinion that this student is able to participate in clinical activities with the exception of any limitations as noted below.

☐ **Yes** ☐ **No**

Limitations:_____

Provider Signature:_____ **Date:**_____ **Phone:**_____

Provider Name (printed):_____ **Office Address:**_____

Credentials: ☐ **MD** ☐ **DO** ☐ **PA** ☐ **APRN** _____

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Documentation of Evidence of Immunity – to be completed by healthcare provider

Student Name:_____ **DOB:**_____

Documentation of evidence of vaccine administration must be provided for all vaccines listed below. Documentation of titers required where indicated:

- **COVID-19** – Documentation of completed primary vaccine series ***and*** 1st booster

  Manufacturer: _____ Lot #:_____ Date:_____

  Manufacturer: _____ Lot #:_____ Date:_____

  Manufacturer: _____ Lot #:_____ Date:_____

  Manufacturer: _____ Lot #:_____ Date:_____

- **Hepatitis B** – dates of immunization & HBsAb titer required

  Dose 1: ___/___/___

  Dose 2: ___/___/___ (one month after dose 1)

  Dose 3: ___/___/___ (5 months after dose 2)

  Titer Results (at least 1-2 months after final dose with required lab report attached)

  ☐ Positive
  ☐ Negative

- **Influenza** – documentation of seasonal flu vaccine

  Manufacturer: _____ Lot #:_____ Date:_____

- **MMR** – dates of immunization & positive IgG titer required

  Dose 1: ___/___/___

  Dose 2: ___/___/___ (4 weeks after dose 1)

  Titer Results (with lab report attached)

  ☐ Positive
  ☐ Negative

- **Tdap** – current tetanus, diphtheria, acellular vaccine within 10 years

  Tdap dose: ___/___/___ (< 10 years)

- **Tuberculosis** – Two-step TB skin test ***or*** IGRA (QuantiFERON); If either is positive, chest X-ray required

  TB Blood Test (IGRA, i.e. QuantiFERON) ***preferred***

  Date of Blood Draw: ___/___/___

  Result: ☐ Positive ☐ Negative

  TB Skin Test (must be 2-step)

  Test #1: Date Placed: ___/___/___

  Date Read: ___/___/___ Result:_____

  Test #2: Date Placed: ___/___/___

  Date Read: ___/___/___ Result:_____

  **If either TB test is positive, chest x-ray required, with lab report attached

  Date of X-ray: ___/___/___ Result: ☐ Positive ☐ Negative

- **Varicella** – dates of vaccination (28 days apart) ***or*** positive IgG titer

  Dose 1: ___/___/___

  Dose 2: ___/___/___ (28 days after dose 1)

  Titer Results (with lab report attached)

  ☐ Positive ☐ Negative