BROOKDALE COMMUNITY COLLEGE
NURSING/ALLIED HEALTH ANNUAL HEALTH CLEARANCE

To be completed and signed by student/faculty:

NAME: _____ DATE OF BIRTH: (mm/dd/yyyy)_____

STUDENT ID #: _____ PROGRAM: ☐Nursing ☐Respiratory Care ☐Rad Technology ☐Other PHONE #:_____

SEMESTER/YR: _____ EMAIL: _____

I understand I must meet all health care requirements mandated by the NJ Dept. of Health and the JCAHO for employees of any health care facility. I understand the agency to which I am assigned may require more health data than listed below. I hereby authorize Brookdale Community College to release my health clearance and immunization documentation (including laboratory reports and immunizations waivers) to any health care agency which may require it in connection with my participation in a clinical course. I also understand that it is my responsibility to update my Annual Health Clearance form annually. I have provided the original of the required completed/signed health clearance documents and kept an additional copy for my own record.

Student Faculty/Signature: _____

To be completed and signed by health care provider:

History and Physical

- By signing below, I have determined that the named individual is eligible for clinical practice and agree with the following statements: I find him/her to be in good physical and mental health; he/she is free from any health impairment which is of potential risk to patients, personnel, students or faculty and which might interfere with the performance of his/her nursing or allied health career responsibilities

Tuberculosis Screening

Either a Mantoux TB (PPD) skin test *or* an interferon gamma release assay (IGRA) blood test such as QuantiFERON TB Gold is acceptable

- If submitting a PPD:
  An initial 2-step PPD (Mantoux) skin test is required (2 PPD tests done one to three weeks apart) unless a PPD was done within the last calendar year, after completing the 2-step PPD.
- If IGRA test is performed, laboratory report and test results must be submitted

PPD (Mantoux) # 1: Date Administered: _____ **Date Read:** _____ ☐**Negative** ☐ **Positive**

PPD (Mantoux) # 2: Date Administered: _____ **Date Read:** _____ ☐**Negative** ☐ **Positive**

OR

IGRA: Date Administered _____ **(must be within past 12 months)** ☐**Report Attached** ☐**Negative** ☐**Positive** ☐**Indeterminate** **(positive/indeterminate findings require repeat testing)**

PPD or IGRA Positive/Indeterminate Findings

Negative chest X-Ray report within 12 months of starting program is required. This is a one-time only requirement as long as patient is asymptomatic. X-Ray report must be attached

- **Date of Chest X-Ray** _____ ☐ **X-Ray report attached** ☐**Normal X-Ray** ☐ **Abnormal X-Ray**
- ☐ **Annual completion of risk assessment shows patient is asymptomatic**
- **If abnormal X-Ray: Patient was/is treated with prophylactic medications. Date treatment started** _____

Annual Influenza Vaccine*

See Student/Faculty Influenza Vaccine Documentation form

Signature of health care provider: _____ **Date:** _____

Print name: _____

License #: _____ **Phone #:** _____

Address: _____

Updated 2.27.17 JE