PRACTICAL NURSE PROGRAM

ASSABET LPN

BE. MORE.

HEALTH CLEARANCE

Completed document due: June 5, 2020

PN Student Name: _____ Date of Birth: _______________

For the protection of students, patients, faculty and other personnel, individuals accepted to the Practical Nursing (PN) Program must provide documented proof of specific immunizations and/or immunity as appropriate, as well as completing a comprehensive screening for substances of potential impairment or abuse. Certain clinical agencies have immunization requirements that exceed those of the MA Department of Public Health and as a result the Program cannot make any exceptions. Failure to provide all required documentation may exclude the PN student from clinical practice and participation in the Program.

TO BE COMPLETED BY THE STUDENT'S HEALTH CARE PROVIDER

This is to verify that _____, was examined by me on _______________.

Summary of Findings (check one):

- ☐ Well student; no conditions identified that would limit the ability to participate in the PN Program and safely perform nursing activities.

- ☐ Conditions have been identified that would limit the ability to participate in the PN Program and perform nursing activities. The identified condition(s) does not pose a risk to safe nursing practice. (Please Identify condition, limitations, rationale for, and duration of the specific limitations.)

  _____

  _____

  _____

By signing below, I find her/him to be free of any health impairment which is of potential risk to students, patients, faculty, and other personnel and which might interfere with the safe performance of her\his nursing student responsibilities, with or without reasonable accommodation. Habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances that may alter the individual's behavior has been considered in this evaluation.

Signature* of Examining Healthcare Provider: _____ Date: _______________

(*Stamp is NOT ACCEPTABLE in place of signature)

Stamp, copy of letterhead, or business card may be used for the following required information:

Print Name: _____

Office or Agency Name: _____

Address: _____

Telephone Number: _____

STUDENT: Please retain a copy of this document for your records.

This page to be completed and signed by the Health Care Provider.

Student's Name: _____Date of Birth: _____/_____/_____

Tuberculin (PPD) – within 6 months of program start. **MANDATORY 2 STEP**

Date: _____/_____/_____ **Result: _____** **If Positive:** Chest x-ray _____
or IGRA **or**
Date: _____/_____/_____ **Result: _____** **QuaniFERON-TB Gold** _____

IMMUNIZATIONS

Measles, Mumps, Rubella

MMR x 2: Vaccine #1 date: ____/_____/_____ Vaccine #2 date: _____/_____/_____ **OR** Positive Titre:
Measles_____
Mumps_____
Rubella_____

Chicken Pox

Varicella x 2: Dose #1 date: ____/_____/_____ Dose #2 date: _____/_____/_____ **OR** Positive Titre: _____

Hepatitis B

Hepatitis x 3: Dose #1 date: ____/_____/_____ Dose #2 date: _____/_____/_____ Dose #3 date: _____/_____/_____

AND Positive Titre: _____ One to two months after completion of the series.

T DaP within 10 years: _____

Meningitis (if 21 or under): _____ booster over 16 years under 21 years

Seasonal Flu prior to October 31st of school year: _____

SIGNATURE OF HEALTH CARE PROVIDER OR DESIGNEE IS REQUIRED

_____ _____
Signature *Printed name*

_____
Street Address / City / State / Zip