STAND ON PROMISE NURSE ASSISTANT PROGRAM

MEDICAL CLEARANCE FORM

Student Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / _____
- **Phone Number:** _____
- **Email Address:** _____

Section A: Required Immunizations

Please attach **official documentation or titer results** verifying immunity or vaccination completion.

Vaccine Name	Date(s) Administered	Titer Attached (if applicable)	Provider Initials
Tdap (within last 10 years)	_____	☐ Yes ☐ No	_____
MMR (Measles, Mumps, Rubella – 2 doses or positive titer)	_____	☐ Yes ☐ No	_____
Varicella (2 doses or positive titer)	_____	☐ Yes ☐ No	_____
Hepatitis B (3 doses or positive titer)	_____	☐ Yes ☐ No	_____
Influenza (Current season)	_____	N/A	_____

Section B: Tuberculosis Screening

Please check one of the following and attach results:

☐ **TB Skin Test (PPD)** – Date placed: _____ Date read: _____ Result: _____ mm
☐ **TB Blood Test (IGRA – Quantiferon/T-Spot)** – Date: _____ Result: _____
☐ **Chest X-Ray** (If TB test is positive) – Date: _____ Result: _____

Section C: Urine Drug Screen

☐ Urine Drug Screen completed on: ____ / ____ / _____
☐ Results attached ☐ Pending ☐ Cleared

Section D: Physical Examination & Functional Abilities

To be completed and signed by a licensed healthcare provider (MD, DO, NP, PA):

I certify that the above-named student has undergone a physical examination and, to the best of my knowledge:

- Is **free from communicable diseases** and in **good physical health**.
- Is **capable of lifting up to 50 pounds**.
- Is **able to stand and perform physical tasks for up to 12 hours** without restrictions.

Provider Name (Print): _____
License Number & State: _____
Signature: _____ Date: ____ / ____ / _____
Clinic Name & Address: _____
Phone: _____