New Jersey City University
College of Professional Studies
Nursing Department

HEALTH CLEARANCE FORM

Name:_____

Instructions: This form must be completed by the Health Care Provider *in addition* to the NJCU Student Health Record. Submit this document to the Nursing Department once all items are completed.

TUBERCULIN SCREENING

PPD STEP 1: Date given:_____ Date read:_____ Results (in mm): _____

PPD STEP 2: Date given:_____ Date read:_____ Results (in mm): _____

CXR if PPD Positive: please attach results

TITERS

Measles: ☐ Immune (attach results) ☐ Not Immune (requires vaccination)

Mumps: ☐ Immune (attach results) ☐ Not Immune (requires vaccination)

Rubella: ☐ Immune (attach results) ☐ Not Immune (requires vaccination)

Varicella: ☐ Immune (attach results) ☐ Not Immune (requires vaccination)

Hepatitis B: ☐ Immune (attach results) ☐ Not Immune (vaccination recommended)

Note: Equivocal results are not accepted. Revaccination required if results equivocal. Students requiring revaccination will require follow-up titers.

VACCINATIONS

Hepatitis B #1: Date given:_____ Hepatitis B #2: Date given:_____

Hepatitis B #3: Date given:_____ Tdap (preferred) or Td: Date given:_____

Other (please specify):_____ Date given:_____

I certify the above individual is in good health, has no limits on physical activity and is free of contagious diseases.

Health Care Provider Date

Revised April 17, 2010