Date: March 15, 2017
To: Class of 2019
Re: Health Clearance Forms for Didactic Year

Please visit your primary health care provider to complete your health clearance forms. Please read and review all paperwork carefully, before and after leaving your health care providers office. It is your responsibility to ensure that these forms are properly completed. **Make a photocopy of all of this paperwork (including all results of blood work) as you WILL need this to see patients and to deliver it to all of your clerkship sites.** You will also need copies for places of employment once you have graduated.

With the exception of immunizations and tuberculosis screening tests (PPD and/or CXR), faculty and staff are unable to review student medical records. Review of immunization and tuberculosis screening tests is only permitted with student written permission (a consent form is enclosed, please review and sign). Keeping this in mind, do not submit any documentation or test results that do not pertain to immunization or tuberculosis screening tests. The program is only allowed to review information related to measles (rubeola), mumps, rubella, varicella, tetanus, hepatitis, tuberculosis skin test (PPD), CXR results if positive PPD and documentation of anti-tuberculosis therapy if initiated. **If other lab results are included on the report form, please white these out and make a copy for submission to the program. A full written physical examination should NOT be submitted to the program.**

If a health condition arises during the course of study that would in any way alter a student’s ability to perform in the clinical setting, it is the student’s responsibility to notify the Director of the department of Physician Assistant Studies immediately. All students are required to have adequate health insurance for the entirety of their time in the PA Program. Selected clinical agencies may require evidence of health insurance. If you are placed at such an agency, it will be necessary for you to provide this evidence. Inquiries regarding health insurance availability through the University can be found at the Health and Wellness Center, Hofstra University, Republic Hall, North Campus. Their phone number is 516-463-6745 and web site is hofstra.edu/StudentAffairs/StudentServices/welctr/index.html.

**STUDENT INSTRUCTIONS FOR HEALTH CLEARANCE**

There are 2 sets of forms that must be filled out.

1) **PA Program** health clearance forms.
   a. Due date: **MAY 20, 2017**
   b. Send to: Gia Raponi via fax at 516-463-5177 or email at Gia.R.Raponi@Hofstra.edu.
   c. Questions should go to Gia Raponi at 516-463-4043 or email at Gia.R.Raponi@Hofstra.edu.

2) **University** health clearance forms. Can be found at http://www.hofstra.edu/pdf/studentaffairs/studentservices/welctr/medical%20records%20copy.pdf. The University forms should NOT be sent to the PA program but should be sent to Hofstra.
The following instructions are for completing PA Program health clearance forms.

1) Northwell Health form titled “Employee Health Services – Student Medical Clearance”:
   a. The student should fill out your name, date of birth, sex, telephone number, email, and school on the top part of the form. Write N/A under the heading “Northwell Health Rotation Information”.
   b. The bottom half must be filled out by a health care provider. However, students must make sure the following guidelines are met and forms are filled out properly.
      • Measles (Rubeola), Mumps, Rubella and Varicella quantitative titer (blood work with a number on it) is REQUIRED. This means blood levels have to be drawn unless you have copies of old titers. If you do, bring them to your health care provider, they do not need to be drawn again unless your titer was low and you have since received a booster. For each immunization, you must have either:
         - A positive quantitative titer. A copy of the lab results (blood work/titer) with the positive titer must be submitted.
         OR
         - If the titer is showing you are not immune, documentation of the initiation of the vaccine must be submitted. Documentation in the form of a copy of the patient record or a written letter from your health care provider indicating administration of the immunization is required.
      • The date of a tetanus/diphtheria/pertussis (Tdap) or Tetanus diphtheria (Td) vaccine administered within the last 10 years is required must be documented on the form. As stated by the CDC guidelines, “All health care providers who have not or are unsure if they have previously received a dose of Tdap should receive a one-time dose of Tdap as soon as feasible, without regard to the interval since the previous dose of Td. Then, they should receive Td boosters every 10 years thereafter.”
      • Influenza vaccination: The health care professional should fill out this section as indicated on the form. During flu season, the Program will ask students to obtain a flu vaccine and provide the program with documentation.
      • Hepatitis B vaccines are strongly recommended. One of the following is required:
         - A positive Hepatitis B surface antibody titer. Copy of the lab results (blood work/titer) with the positive titer must be submitted.
         OR
         - If the titer is showing you are not immune, documentation of the initiation of the vaccine must be submitted. Documentation in the form of a copy of the patient record or a written letter from your health care provider indicating administration of the immunization is required. Also, the document titled “Hepatitis Vaccine Refusal Form” must be completed and submitted while in the process of vaccination.
   OR
• If you are declining to have hepatitis B vaccination, complete and submit the document titled “Hepatitis Vaccine Refusal Form”. Please note that many hospitals are starting to require hepatitis B vaccines and titer’s. Not being able to provide proof of hepatitis B immunity could prevent you for obtaining medical at certain medical facilities.

• **TB Screening:** The healthcare professional should fill out this section as indicated on the form. Either the traditional TST/PPD or a Blood Assay (Quantiferon TB Gold) can be used. History of BCG is NOT a contraindication to PPD testing.

• The health care provider must print, sign, date, provide a phone number and STAMP the bottom.

2) **Physical Examination:**
   a. The student should fill out your name and date of birth on the top of the form.
   b. The health care provider must print, sign, date, provide a phone number and STAMP the bottom.

3) **Consent for release of confidential health information:** The student consent form allows program faculty and staff to maintain and release immunization and tuberculosis screening results. Clinical sites often request student documentation of health clearance. Please read, sign and return to the program.
   a. The student should fill out the name, sign, and date.
Employee Health Services
Student Medical Clearance

Name: ___________________________ DOB: _____/____/____

☐ Male  ☐ Female  Telephone: ( ) ___________________________ Email: ___________________________

School: ___________________________

Northwell Health Rotation Information

Northwell Health Rotation Location: ___________________________ Department: ___________________________

Rotation Start: ____/____/____  Rotation End: ____/____/____  Email Med. Clearance to: ___________________________@northwell.edu

TO BE COMPLETED AND SIGNED BY YOUR HEALTHCARE PROVIDER OR FACILITY

Mandatory Immunity Required

<table>
<thead>
<tr>
<th>Measles (Rubeola)</th>
<th>☐ Immunity Confirmed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mumps</td>
<td>☐ Immunity Confirmed</td>
</tr>
<tr>
<td>Rubella (German Measles)</td>
<td>☐ Immunity Confirmed</td>
</tr>
<tr>
<td>Varicella</td>
<td>Immunity Confirmed</td>
</tr>
<tr>
<td>Tdap/DTaP (Pertussis containing vaccine within last 10 years)</td>
<td>Date Vaccinated: <strong><strong>/</strong></strong>/____</td>
</tr>
</tbody>
</table>

Influenza

Vaccinated within the current flu season

☐ Vaccinated  ☐ Not Vaccinated

Complete Hepatitis B Section for individuals that have Direct Patient Care Contact.

| Hepatitis B | ☐ Immune  ☐ Declined Vacc. or Initiated Series |

Tuberculosis (TB) Screening:

Tuberculin Skin Testing (TST/PPD) or Blood Assay

TB screening must be within the past 12 months or check the positive box below, if the individual has a positive tuberculin skin test.

☐ Negative – Date Completed: ____/____/____

☐ Positive (Complete Positive TST/PPD Section below)

Positive TST/PPD: If you have a history of a positive TST/PPD, complete the chest x-ray and signs and symptoms section below.

You must have had a chest x-ray with no active disease.

Chest X-Ray

Date: ____/____/_______  Result: ☐ No Active Disease  ☐ Other _______________________

TB treatment given: Date(s): _______________________

Tuberculosis Signs and Symptoms Evaluation within last 12 months

Date of Review: ____/____/_______  Results: ☐ Negative  ☐ Positive

Health Assessment: The above individual has been evaluated in the past 12 months. The results of our evaluation is of sufficient scope to ensure the above named person is free from health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, other drugs or substances which may alter the individuals behavior. The office that is completing this form will be responsible for maintaining updated records for the duration of participant’s and/or faculty’s interactions within the Northwell Health facilities and provide appropriate supporting documentation upon request.

Health Care Provider or Facility: ___________________________ Phone: ___________________________

(Please Print) (School designee if applicable)

Health Care Provider or Facility Signature: ___________________________ Date: ___________________________

Provider/Facility Stamp with Address and Telephone Number:
PHYSICAL EXAMINATION:
To be completed by a health care provider

Student Name:_______________________________________ Date of Birth:________________

A thorough exam was completed on the above named individual. I find him/her to be in good health. He/She is free of any health impairments which may pose potential risk to patients or personnel, or which may interfere with the performance of clinical responsibilities. Habituation to alcohol or other drugs which may alter the individual’s behavior has been considered in this evaluation. After a review of all health information I certify that this student is found to be in good physical and mental health and appears able to perform physician assistant student responsibilities with ______ or without ______ accommodations.

____________________________________________           Date___________________
Signature of examining health care provider

____________________________________________           _______________________
Print Name                                                                                 Telephone number

Practitioner’s stamp (Required):
CONSENT FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION
To be completed all students

I ______________________________, hereby authorize The Physician Assistant Studies Program at Hofstra University, to release all or part of my medical record to the clinical sites in which I am assigned. I hereby authorized faculty and staff of the program, to maintain and release immunization and tuberculosis screening results. I understand that all other medical records will remain confidential and will not be accessible to or reviewed by program faculty or staff.

(Student Signature AND Date)
HEPATITIS VACCINE REFUSAL FORM
To be filled out by student (if necessary)

To be signed by any student who has declined to be vaccinated against Hepatitis B OR who is in the process of becoming immunized but does not have a demonstrable immunity by HbsAb antibody titer (blood work) at this time.

______________________________  ___________________________
Student Name  Student ID

I understand that due to my occupational exposure to blood and other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection.

I have been given the opportunity to be vaccinated with Hepatitis B vaccine. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

If in the future I continue to have occupation exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series from my private health care provider at any time.

______________________________  ____________________________  ____________________________
Student  Date  Student Name (PRINT)