

DAEMEN COLLEGE CLINICAL HEALTH FORM

SUBMISSION OPTIONS: ONLINE: daemen.edu/healthupload | FAX: 716.839.8230
OFFICE: Wick 116, CHIP Center | MAIL: 4380 Main St. Box #104 Amherst, NY 14226



PART 1 – STUDENT INFORMATION

LAST NAME FIRST NAME MIDDLE INITIAL DATE OF BIRTH PREFERRED PHONE (WITH AREA CODE)

PROGRAM: AT PA PT NUR CLINICAL SEMESTER(S): SU FA SP year 1 (PA) GRAD YEAR: _____

PART 2 – RECORD OF IMMUNIZATIONS FOR VERIFICATION

Provider may fill out the form below or attach immunization dates, results and interpretations. **ONLY DATES IN MM/DD/YY FORMAT ACCEPTED.**

Measles, Mumps, Rubella (MMR)

As required by NYS Public Health Law 2165 students submit this upon admission to the college. Please contact the Daemen College Health Services to obtain copies to submit to for clinical.

Hepatitis B (Choose one of three options below)

- 3 Vaccinations: ____ / ____ / ____ ____ / ____ / ____ ____ / ____ / ____
- Hepatitis B – Positive Titer (attach lab report with date of titer, reading and interpretation of the result)
- Complete Hepatitis B declination form (only permitted for clinical sites that accept declinations)

Varicella (Chicken Pox) (Choose one of three options below)

- 2 Vaccinations: ____ / ____ / ____ ____ / ____ / ____
- Disease Date: ____ / ____ / ____
- Varicella – Positive Titer (attach lab report with date of titer, reading and interpretation of the result)

Tdap/TD – MUST BE COMPLETED WITHIN 10 YEARS (tetanus, diphtheria, and pertussis)/(tetanus and diphtheria)

- Tdap vaccination: ____ / ____ / ____
- TD vaccination (if applicable): ____ / ____ / ____

Tuberculosis Screening – MUST BE COMPLETED WITHIN 1 YEAR OF CLINICAL EXPERIENCE START DATE (Choose one of three options below)

- Mantoux Tuberculin Skin Test: Test Date: ____ / ____ / ____ Read Date: ____ / ____ / ____ Result: _____
2-step PPD: encouraged for PA students
- QuantifERON TB Gold Blood Test: Test Date: ____ / ____ / ____ Result: _____ (Attach lab report)
- T-Spot Blood Test: Test Date: ____ / ____ / ____ Result: _____ (Attach lab report)

Positive result for any of the aforementioned tests – Chest X-Ray Required (attach lab report)

Date of X-Ray: ____ / ____ / ____ Result: _____

Positive chest x-ray: will/did the student complete treatment? Y: ____ N: ____

(Attach documentation as follows: Y: treatment plan and restrictions; N: care plan to monitor condition)

Flu Shot – MUST BE COMPLETED EACH FLU SEASON (Choose one of two options below)

- Vaccination date: ____ / ____ / ____
- Complete a flu declination form & wear a mask during clinical(s)

PART 3 – PHYSICAL EVALUATION

MUST BE COMPLETED WITHIN 1 YEAR OF CLINICAL EXPERIENCE START DATE

Student is encouraged to complete a medical history form from their provider's office prior to having an examination completed.

- Date of physical Examination: ____ / ____ / ____
- Clinical Experience Physical Evaluation
(if there are concerns about student participation, please attach documentation regarding concern(s))
 - Is this person free from communicable diseases that could jeopardize the health of others? Y: ____ N: ____
 - Are there any restrictions of physical activity indicated by your examination? Y: ____ N: ____

Provider Name (print or stamp)

Provider Signature

Provider Address & Phone Number

Date