ALAMEDA COUNTY MEDICAL CENTER

Employee Health Services Phone 510.346.7551 Fax 510.346.7579
Attention Student Placement
15400 Foothill Blvd., San Leandro, CA 94578 Bld. C Ground Floor

STUDENT HEALTH SCREENING CLEARANCE

Please print:

Student Full Name: _____ School Name: _____
LAST NAME FIRST NAME MIDDLE INITIAL

Dates of Placement & Days/Hours: / / - / / D.O.B___/___/____
START DATE END DATE

Student Title: _____ Student email: _____ & phone: _____

PLEASE SELECT ONE FOR PROGRAM AND SEMESTER

Please note: This form is to be completed by your Health Care Provider or School Licensed Clinician*

TUBERCULOSIS SCREENING: (Must show proof below by indicating initial dates of initial 2 Step PPD & most current PPD. If "current date of PPD" shows a lapse in date, then a 2 step will need to be administered. Current PPD cannot expire during rotation, if so one must be administered)

A. 2 Step: Date of PPD #1: _____ Results: _____ mm induration
Date of PPD #2: _____ Results: _____ mm induration
(CURRENT) Date of PPD: _____

Or if history of positive TB skin test

B. Chest x-ray date: _____ Results: _____
(Chest x-ray within past 4 years must include documentation of positive PPD history & Symptom Review Survey)

C. Symptom Review Survey: _____ Results: _____

D. QuantiFERON Test Date: _____ Results: _____

VACCINATIONS (enter date):

VACCINATION	SERIES	DATE	SERIES	DATE	Series	DATE	Declination Date
MMR:	#1		#2				
Varicella:	#1		#2				
Hepatitis B:	#1		#2		#3		

DATE OF OTHER VACCINE TDAP: _____ FLU: _____ OTHER: _____ Declination Date: _____

TITERS:

Mumps:	Date of titer: _____	☐ Immune	☐ Non-immune
Measles:	Date of titer: _____	☐ Immune	☐ Non-immune
Rubella:	Date of titer: _____	☐ Immune	☐ Non-immune
Varicella:	Date of titer: _____	☐ Immune	☐ Non-immune
Hepatitis B:	Date of titer: _____	☐ Immune	☐ Non-immune

MASK FIT: (Must be 1860 KC Tecnol Non Industrial or Max Air PAPR)

Date: _____ Type: _____ Size: _____ **Or** PAPR Date: _____

FOR SCHOOL LICENSED CLINICIAN OR MEDICAL PROVIDER:

I hereby certify that the above health information given is complete, true and accurate to the best of my knowledge. Incorrect information may result in removal of Student Placement Program until student health requirements are fulfilled. Failure or neglect to disclose accurate information may be grounds for removal from student placement program and review of affiliation agreement.

****Note: This form should reflect Employee Health Screening Requirements. Upon review of this form, ACMC representative will advise of any incomplete health screening requirements. School representative will have 10 business days from notification to fulfill incomplete items to ACMC.

Signature of Licensed Clinician: _____

Print Name of Licensed Clinician: _____ Date: _____

Employee Health Services USE ONLY: (FINAL CLEARANCE SIGNATURE FROM ACMC EMPLOYEE HEALTH NURSE)

Initial Review Date: _____

Signature of Licensed Clinician: _____ Date: _____