UCNJ Union College of Union County, NJ
Division of Allied Health Sciences

STUDENT HEALTH FORM

NOTICE

COVID-19 VACCINE IS REQUIRED FOR ENROLLMENT IN ANY HEALTH SCIENCE PROGRAM

INSTRUCTIONS

This health form must be completed and uploaded into the Castle Branch account of the program to which the student was admitted.

Student ID #: _____

Name: _____ **Program:**_____

Address: _____

_____

_____

Phone: (home) _____ (cell) _____ (work) _____

Personal Health Overview (to be completed by the STUDENT)

List any current health problems/medications taken:

_____

_____

Known Allergies:

_____

Physician Statement (to be completed by Licensed Physician, Physician Assistant or Nurse Practitioner):

I have received and reviewed the functional job description for the program listed above and attest that the student listed on this form was examined by me and found to be in good physical condition and is physically able to participate in the above referenced healthcare program at UCNJ Union College of Union County, NJ.

Physical Exam completed: _____(DATE) Limitations in physical activity? ☐ Yes ☐ No

If yes, please explain: _____

Any other specific information, such as activity restrictions, should be uploaded

The student is free of communicable diseases: ☐ Yes ☐ No

If no, please explain: _____

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Laboratory: (lab results must be uploaded to Castle Branch. Not to be completed by EMT students.)

Test	Date	Within Normal Limits	
CBC	_____	☐ Yes	☐ No
Urinalysis	_____	☐ Yes	☐ No
Blood Chemistry/Metabolic Panel	_____	☐ Yes	☐ No

**Any abnormalities found require documentation by the provider and approval to participate in the program indicated. A positive drug screening may interfere with your ability to go to the clinical sites.*

Immunizations: Lab results must be uploaded to Castle Branch

*Quantitative blood titer levels need to be completed regardless of immunization status! Receipt of vaccine or history of the disease does not demonstrate immunity status. After any vaccines are received, a follow-up blood titer may be done to determine immunity. Actual blood titer values and immunity status **for each** are required to be **written in this form by the healthcare provider.**

Vaccine	Date Received	Immunity Status	Follow-up Titers	Blood Values
Measles	_____	Immune ☐ Yes ☐ No	Immune ☐ Yes ☐ No	_____
Mumps	_____	Immune ☐ Yes ☐ No	Immune ☐ Yes ☐ No	_____
Rubella	_____	Immune ☐ Yes ☐ No	Immune ☐ Yes ☐ No	_____
Varicella	_____	Immune ☐ Yes ☐ No	Immune ☐ Yes ☐ No	_____
Hepatitis B	1st dose_____	Immune ☐ Yes ☐ No	Immune ☐ Yes ☐ No	_____
	2nd dose_____	Immune ☐ Yes ☐ No	Immune ☐ Yes ☐ No	_____
	3rd dose_____	Immune ☐ Yes ☐ No	Immune ☐ Yes ☐ No	_____

Hepatitis C: Negative ☐ Positive ☐

Flu Vaccine – Annual Requirement: ☐ Yes ☐ No Date Received: _____

COVID-19 Vaccine: 1st Dose ☐ Date Received: _____ 2nd Dose ☐ Date Received: _____

Booster Dose ☐ Date Received: _____

Tetanus, Diphtheria, Pertussis Vaccine (Tdap): Date Received: _____
*Receipt of Tdap vaccine must be within 2 years of the date of this form.

NOTE: If vaccines are declined, signed copies must accompany this form. Students who are not immune to the infectious disease noted may be prohibited by the clinical affiliates from participating in clinical experiences in areas where disease transmission poses a high risk to patients, staff, visitors and / or students.

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Drug Screening: (lab results must be uploaded to Castle Branch)

A 10-panel screening is required for: **Practical Nursing** (PNU); **Physical Therapist Assistant** (PTA) and **Respiratory Care** (RSP) and **Paramedic** (PMD) programs.

Urine Drug Screening with confirmation: Date: _____ Negative ☐ Positive ☐

Tuberculosis Testing:

** TST, PPD, Mantoux or Qft testing, chest x-ray or pulmonary clearance is required on an annual basis.

Test	Date	Results
Two-Step Mantoux	_____	Negative ☐ ** Positive ☐
Chest X-Ray	_____	_____
Medication Prescribed:	_____	
Pulmonary Clearance	_____	(upload forms)
QuantiFERON Gold	_____	_____

** A two-step test is not required if documentation is provided of a negative result is documented within 12 months of the date noted by the healthcare provider. Students who have received a prior BCG vaccine are required to perform alternate testing (such as QuantiFERON Gold) as well as have chest x-ray or pulmonary clearance from the healthcare provider.

** A positive PPD will require the student to complete a TB questionnaire: Date: _____

_____
Examiner's Name, Credentials, License # & Address
(Official Stamp is ***REQUIRED***)

_____ _____
Examiner's Signature (***REQUIRED)*** Date