Student's Name (Last, First, MI) ____ Alliance ID _______________

Alliance University School of Nursing Medical Clearance Instructions

1. Each student is responsible for payment related to medical clearance requirements by the School of Nursing and by clinical facilities. Each student must also upload documents in Castle Branch to be cleared.
2. Background Check under Castle Branch
https://portal.castlebranch.com/NY81
3. Valid **American Heart Association** Basic Life Support Certification every 2 years
Click Here for AHA BLS Example
4. N95 Fit Testing - Halyard N95 Respirator Fit Testing to be done annually
Click Here for Halyard N95 Example
5. Provider's medical clearance to work in health care settings.
    - Completed the Annual Physical health form by MD, DO, NP, or PA.

    Click Here for Health Form
    - Signed and stamped with license number with date.
    - Stamp of the healthcare organization that the provider is working and performed the medical clearance.
    - This documentation is good for 1 year from the date of health professional signature.
    - Must attach MMR, Varicella, Hep B titer results.
    - NOT ACCEPTABLE: Provider's handwriting in "immune" or "Titer Number" without actual blood titer test results.
6. Initial QuantiFeron TB Gold test or two steps PPD results within one week apart.
    - The first initial two steps of PPD tests mean a clinician must implant PPD two times and read the result two times. (first time: 5/10/21 implanted, 5/13/21 result 0 mm, second time: 5/17/21 implanted, 5/20/21 results 0 mm)
    - Then, an annual PPD or annual QuantiFeron TB Gold test is required.
    - If you have had a positive PPD, you must provide documentation of a clear chest x-ray after exposure and documentation that you are symptom-free. You must include a copy of the current chest x-ray report.
    - **If positive**, include the following information in the medical clearance note.
        - Size of reaction in centimeters
        - Did you receive prophylaxis? Yes No
        - If prophylaxis was received, specify drug(s), dose and time frame.
        - Date of last chest X-ray:_________ Results:____________
7. MMR (Measles, Mumps, Rubella) blood test titer results.
    - If the results are not immune, proof of two MMR vaccinations and students must receive a booster. Repeat titers to be completed 1 month after booster.
8. Varicella (Chicken Pox) blood test titer result
    - If the result is not immune, proof of Varicella vaccination and the student must receive a booster. Repeat titers to be completed 1 month after booster.
9. Hepatitis B Surf Antibody (Ab) test results should be reactive.

- If not reactive, Hepatitis B Surface Antigen (Ag) and Hepatitis Surface Antibody (Ab) test is required.
- If not reactive, proof of 3 Hep B vaccinations

Click Here for Hep B Example

10. Adult Tetanus/Diphtheria (Td) vaccination must be within 10 years.
11. Influenza Vaccination Proof: Full details of flu vaccine documentation
    - Lot
    - Manufacturer
    - Expiration date of flu vaccine
    - Date of administration
    - Provider's name and license number

    *Influenza is required annually
12. Forensic Urine Drug Toxicology monitoring 10 panel result at Castle Branch at the start of the first clinical practicum rotation then annually (date specified by clinical facility or SON)

Click Here for Castle Branch Drug Test Example

13. Covid-19 Vaccination Record Card completed with first dose, second dose, and booster before starting clinical rotation or specified by clinical facility.

Student's Name (Last, First, MI) ____ Alliance ID _______________

Instructions to upload health documents for Castle Branch:

1. Go to the site below:
https://portal.castlebranch.com/NY81

2. Click on package selections (second tab from the left).

3. Select: **NY81: Background Check - Compliance Tracker - Drug Test**
(This package includes your Background check, Drug Test, and Medical Clearance to submit your medical documents on your account)

4. Read the instructions and click the box that you have read the instructions. Then click on the green box to continue.

5. Click the box that you have read the instructions and then click the orange continue box.

6. Fill out the information and pay $143.75 to Castle Branch.

7. Make an appointment and submit your sample.

Student's Name (Last, First, MI) ____ Alliance ID _______________

Part I. Demographic Information

Last Name _________________ First ________________ MI _________ Date of Birth ____- ___- _____
mm dd year

Sex: ▢ Male ▢ Female ▢ Nonbinary Marital Status ▢ Married ▢ Single ▢ Other

Home Address ____ __________ _______ ________________
Number and Street Town State Zip code

Previous Health Practitioner ____________________________ Date of last physical exam ___________

Release of Information Authorization

I give authorization for the release of the Student Annual Health History and Physical Exam Form to the Dean of the School of Nursing, the Health Services and other Hospitals and clinical affiliates where I might be engaged in clinical instruction as part of my academic training.

____
Signature Date

Permission for treatment for students under 18 years of age

When serious medical problems arise, every effort will be made to reach parents, guardians, or spouses. On occasion, we are unable to make this contact. To avoid delay in treatment, we request that the following statement be signed by parents, legal guardian, or spouse.

I hereby grant permission to treat and/or hospitalize my son/daughter/spouse/ward in case of illness or injury.

____ ____
Parent, guardian, spouse's signature Relationship Date

Part II. Health History

Childhood Illnesses: ▢ Measles ▢ Mumps ▢ Rubella ▢ Chickenpox ▢ Rheumatic Fever ▢ Polio ▢ None

Immunization and Dates: ▢ Tetanus ______ ▢ Influenza______ ▢ Hepatitis A _____ ▢ Hepatitis B* ____

▢ MMR ______ ▢ Chickenpox______ ▢ Meningococcal _____ ▢ Pneumonia ______ ▢ COVID Vaccines

▢ Two steps PPD 1st PPD date ____________ 2nd PPD date (At least a week apart) or ▢ Quantiferon ________

Past Medical History ____

Past Surgical History ____

Past Family History (heart disease, DM, cancer, etc) ____

Social History: ▢ Smoking ____________ ▢ Alcohol __________ ▢ Illicit Drug Use ______________
Frequency Frequency Frequency

Student's Name (Last, First, MI) ____ Alliance ID _______________

Allergy (medications, seasonal, or latex allergy) ____

Medication list ____

____

Personal Health History

Has your physical activity been restricted or your education interrupted for medical reasons during the past five years?	Yes	No
Have you had difficulty with school, studies, or teachers?		
Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem?		
Have you had any illness or injury or been hospitalized other than already noted?		
Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years (other than routine checkups)?		
Have you been rejected or discharged from military service because of physical, emotional, or other reasons?		
Do you have the absence of any paired organ (eye, ear, kidney, etc.)?		
Do you have a history or are presently dependent on drugs or alcohol?		

Comments: If you answered "Yes" to the questions above, please explain the problem and its treatment.

____

____

____

Part III. Physical Examination

Student's Name (Last, First, MI) ____ Alliance ID _______________

To the Examining Practitioner:
Please review the student's history and complete applicable parts of the examination form. THIS STUDENT HAS BEEN ADMITTED TO THE SCHOOL OF NURSING. The information will not be used to influence status at the College; it will be used only as a background for providing health care, if necessary, while enrolled as a student. This information is confidential. It will not be released to any without the student's knowledge and consent.

Ht__________________ Wt________________ BP_________/_________Pulse_______________

Vision Right eye (Corrected) _________________ Left eye (Corrected) ______________

Describe any abnormalities of the following system in the space below.

	Normal	Abnormal		Normal	Abnormal
General			Gastrointestinal		
Head, Norse, Throat			Genitourinary		
Eyes			Musculoskeletal		
Ears			Neurological		
Neck- thyroid			Hematology		
Respiratory			Psychiatry		
Cardiovascular			Skin		

	Yes	No
To the best of your knowledge, is the person free from physical or mental impairments, including alcohol or drug dependency?		
Are there any restrictions on physical activity indicated by your examination? Comment if "Yes"		
Is the patient now under treatment for any medical or emotional condition? Comment if "Yes"		
Do you have any recommendations regarding the care of this student? Comment if "Yes"		
How long and in what capacity have you known this student?		

Comments: If you answered "Yes" or "No" to the questions above, please explain the issue.

____

Student's Name (Last, First, MI) ____ Alliance ID _______________

____

____

Must Attach blood tests for titers and vaccination records if the blood test results require immunizations.

▢ Tdap within 10 years ▢ Influenza annually ▢ COVID Vaccines

▢ MMR titer ▢ Varicella titer ▢ Hepatitis B Hep B Surf AB, If the antibody is non-reactive, Hep B Surf Ag result

▢ Two steps PPD (one week apart) 1st PPD date & measure_____________ 2nd PPD date & measure _____________ or

▢ QuantiFERON for the first time, then

Annually ▢ PPD date & measure_______________________________or ▢ QuantiFERON

▢ Chest X-ray report and prophylaxis treatment if PPD is positive.

▢ Influenza and COVID vaccines require a lot number, manufacturer number, and vaccine date, and the name of the clinician.

▢ Forensic Urine Drug Toxicology monitoring 10 panel

Based on the Medical History and Physical Examination of this student, there is NO evidence of Health Impairment which is of Potential Risk to Patients or which interfere with this performance of his/her duties.

___________________________________	_____________	________________	______________________
HCP Name	Title	License #	Date

____	______________________
Address	Telephone

____	______________________
HCP Signature	Date

Stamp of the HCP or Clinic (Required)