Dear Incoming Social Work Student,

There are several forms that must be completed by your healthcare provider prior to matriculation. Completion of these forms will ensure that you meet all State, University, and Program health requirements for enrollment.

SOCIAL WORK PROGRAM FORMS

The Medical Clearance Form is required and should be returned directly to the Program. This form is sent to all incoming students and contains additional requirements above and beyond those required of other university students. It requires a healthcare practitioner to ensure that the student has no medical conditions which could interfere with the social work responsibilities. It also requires up-to-date vaccinations and tuberculosis screening test(s). Please ensure that a healthcare provider completes this form in its entirety to avoid delays and complications.

This form:

- Requires demonstration of immunity to measles, mumps, rubella, tetanus, hepatitis B and varicella (chicken pox).
- Requires proof of immunization for Tdap.
- Requires screening for tuberculosis (TB). The Program screening requirement supersedes any other University requirements regarding tuberculosis screening.

    - Initial TB baseline test: Two-step PPD skin test or Interferon-gamma release assays (IGRAs).
    - A one-step PPD -if the student has documentation of negative PPD within the last 12 months.
    - Any student with a history of a positive PPD will require a chest x-ray and/ or Interferon-gamma release assays (IGRAs) as indicated by the current CDC guidelines.

The next page of this form contains instructions for your healthcare provider.
Please give it to them to review to avoid compliance issues.
Please retain a copy of all documents submitted.

Instructions for Healthcare Provider

Dear Healthcare Provider:

Students matriculating into the social work program are required to meet CDC recommendations for immunizations and tuberculosis screening for healthcare providers. Students **must** have a provider to complete the clearance form.

Medical History

Students are required to undergo a **screening health history** to ensure that they are equipped to meet the demands of a career in social work.
Please simply indicate your recommendation on the Medical Clearance Form. The health history includes:

- Pulmonary
- Cardiac
- Abdomen
- Extremities
  Back/Spine
- Neurologic
- Psychiatric
- Infectious Disease

Immunization History

Required Immunization

All students **must** have been immunized against **diphtheria**, **pertussis,** and **tetanus (Tdap)** within the last 10 years. Please provide a booster if the student has not been immunized within the past 10 years. Tdap titers are **not** acceptable.

Required Titers

All students **must** demonstrate serologic immunity to **varicella**, **measles**, **mumps**, **rubella** and **hepatitis B**. Titers must be no older than 3 years. Please attach copies of all laboratory reports for titers and provide booster vaccinations as necessary. Please see attached form(s) for each condition.

Tuberculosis Screening

All students are required to undergo **ANNUAL tuberculosis screening either via PPD testing or TB serology testing. Please review the Tuberculosis Screening recommendations.** Monovac and Tine testing are not acceptable substitutes for PPD testing. An intradermal PPD test must be placed and read within 48-72 hours by a licensed physician, physician assistant, nurse practitioner, or registered nurse.

Student: Kat Sheffield **Date of Birth:** _____

Matriculation Semester: (Fall) Spring, _____

This form **must** be completed by a licensed physician, physician assistant or nurse practitioner. Please be sure to complete this form in its entirety. Failure to do so may cause a delay in matriculation.

Please check one of the boxes below to indicate your recommendation related to your history and findings. Your signature certifies that you have taken a history as described in the attached "Instructions for Healthcare Provider."

This student is free of any physical or mental impairment(s) which may pose a potential risk to him/herself or to patients or which may interfere with the performance of social work responsibilities.

This student can perform social work responsibilities safely, subject to the following accommodation(s):_____

_____

This student cannot be cleared to practice in a social work environment at this time.

Provider Signature: _____ Date: _____

Provider Name: _____ MD DO PA NP

Office phone number: _____

Office Address:_____

Student, please return this completed form by start of the semester

Student: Kat Sheffield **Date of Birth:** _____

Immunization History

All students are required to meet the following immunization requirements. Please provide copies of all laboratory reports as indicated. Immune titers must be no older than 3 years.

Diphtheria/Pertussis/Tetanus (Tdap): Document vaccination performed within the previous ten (10) years
Date of Immunization: 4 / 15 / 2023

Rubeola (Measles) IgG Titer	**See attached form for more instructions**
Mumps IgG Titer	**See attached form for more instructions**
Rubella (German Measles) IgG Titer	**See attached form for more instructions**
Varicella (Chicken Pox) IgG Titer	**See attached form for more instructions**
Hepatitis B Surface Antibody Titer	**See attached form for more instructions**

**** Please include immunization records (if available).**

Medical Clearance – Final Recommendation

I have seen the above-named student, reviewed their immunization history, and screened them for tuberculosis. I find this student meets the immunization requirements as described above and is free from contagious disease. In my judgment, this student is physically and mentally fit to begin working in a social work environment.

Signature: _____ Date: _____

Name: _____ MD DO PA NP

Address: _____

Phone: _____

Tuberculosis Screening

Student Name: Kat Sheffield DOB: ___/___/___ Entering: Fall, 20_____

Dear Healthcare Provider: All students are required to undergo annual screening for tuberculosis. Tuberculin skin testing or serologic testing is acceptable; please indicate the methodology used below. Please complete this form carefully. Positive results require further action.

Tuberculin Skin Testing (PPD)

PPD #1 Date: 4 / 15 / 23

PPD #1 Induration: 0 mm

PPD #1 Interpretation: ☒ Negative ☐ Positive

If the student does not have a documented negative PPD within the previous 12 months, **a two-step PPD is required.**

PPD #2 Date: ___/___/___

PPD #2 Induration: ____ mm

PPD #2 Interpretation: ☐ Negative ☐ Positive

OR

Serologic Testing

Please attach the lab report

Testing Method: ☐ T-SPOT.TB ☐ QuantiFERON TB Gold

Results: ☐ Negative ☐ Positive* ☐ Indeterminate*

***IN THE EVENT OF A POSITIVE OR INDETERMINATE TEST A CHEST X-RAY IS REQUIRED (ATTACH REPORT)**

Please describe any treatment started:

Healthcare Provider Name: Jane Smith, APNP Signature: [signature] APNP

All lab reports are at student health

Rev. 2/21

Hepatitis B Surface Antibody Titer

Student Name: Kat Sheffield DOB: ____/____/____ Entering: Fall, 20____

Dear Healthcare Provider: All students are required to undergo screening for immunity to Hepatitis B. Please complete this form carefully. Non-compliance may result in student dismissal from a clinical site. **Non-immune results require further action.**

☒ Immune (attach Lab Report). NO further requirements. ☐ Non-Immune **Proceed to re-vaccination** →	**If Non-Immune** **With documentation of previous hepatitis B vaccination series:** If documentation of 3 dose vaccine series exists, healthcare provider may opt to provide a single booster dose of Hepatitis B vaccine; re-titer in 4-8 weeks. If the student remains non-immune, 3 shot series required. **Booster Date:** ____/____/____ **Lacking documentation of previous hepatitis B vaccination series:** If the student lacks documentation of previous Hep B vaccine series or remains non-immune following a single vaccine dose, the full 3 does series is required. Retiter at 4-8 weeks. **HepB 1 Date:** ____/____/____ **HepB 2 Date:** ____/____/____ **HepB 3 Date:** ____/____/____	**HBSAb Re-Titer** ☐ Immune (attach Lab Report) ☐ Non-Immune *

***IN THE EVENT THAT THE STUDENT IS NOT ABLE TO ACHIEVE IMMUNITY, PLEASE EXPLAIN BELOW:**

Provider Name: Jane Smith, AGNP Signature: J Smith AGNP Date: 4/15/23

All lab reports are at student health

Rev. 2/21

Varicella (Chicken Pox) Titer

Student Name: Kat Sheffield DOB: ____/____/____ Entering: Fall, 20_____

Dear Healthcare Provider: All students are required to undergo screening for immunity to Varicella (Chicken Pox). Please complete this form carefully. Non-compliance may result in student dismissal from a clinical site. **Non-immune results require further action.**

☒ Immune (attach Lab Report). NO further requirements ☐ Non-Immune **Proceed to re-vaccination** →	**If Non-Immune** **With documentation of previous Varicella vaccination series:** If documentation of 2 dose vaccine series exists, the healthcare provider may opt to provide a single booster dose of Varicella vaccine; retiter in 4-8 weeks. If the student remains non-immune, 2 shot series required. **Booster Date:** ____/____/____ **Lacking documentation of previous Varicella vaccination series:** If the student lacks documentation of the previous Varicella vaccine series or remains non-immune following a single vaccine dose, the full 2 does series is required. Retiter at 4-8 weeks. **Varicella 1 Date:** ____/____/____ **Varicella 2 Date:** ____/____/____ →	**Varicella IgG Re-Titer** ☐ Immune (attach Lab Report) ☐ Non-Immune *

***IN THE EVENT THAT THE STUDENT IS NOT ABLE TO ACHIEVE IMMUNITY, PLEASE EXPLAIN BELOW:**

Healthcare Provider Name: Jane Smith Signature: J Smith ANP Date: 4/15/23

All lab reports are at Student Health

Rev. 2/21

Rubeola/Mumps/ Rubella IgG Titers

Student Name: Kat Sheffield DOB: ____/____/____ Entering: Fall, 20____

Dear Healthcare Provider: All students are required to meet CDC recommendations related to vaccinations for healthcare providers (for more information, please visit www.cdc.gov.) Please complete this form carefully. **Non-compliance may result in student dismissal from a clinical site.**

Initial Titers		IF Non-Immune	MMR Date(s)	Repeat Titers (If Indicated)
Rubeola (Measles) IgG		**Action is Required for any Non-Immune Titers.** Please Indicate Action Taken:	**If indicated**, please note dates MMR booster(s) administered.	**Rubeola (Measles) IgG**
☒ **Immune** (attach lab report). NO further action is required.	☐ **Non-Immune**	☐ Record of two previous doses of MMR available. **Administer a single dose of MMR and re-titer**	☐ N/A	☐ Immune (attach lab report) ☐ Non-Immune*
Mumps IgG Titer			MMR #1: ____/____/____	**Mumps IgG Titer**
☒ **Immune** (attach lab report). NO further action is required.	☐ **Non-Immune**	**OR**		☐ Immune (attach lab report) ☐ Non-Immune*
Rubella (German Measles) IgG Titer			MMR #2: ____/____/____	**Rubella (German Measles) IgG**
☒ **Immune** (attach lab report). NO further action is required.	☐ **Non-Immune**	☐ NO record of two previous doses of MMR available. **Administer two doses of MMR and re-titer**		☐ Immune (attach lab report) ☐ Non-Immune*

***IN THE EVENT THAT THE STUDENT IS NOT ABLE TO ACHIEVE IMMUNITY, PLEASE EXPLAIN BELOW:**

Healthcare Provider Name: Jane Smith ARNP Signature: Jane Smith ARNP Date: 4/15/23

All lab reports At Student health

Rev. 2/21