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Student Name: _____

New Student Physical Form

Healthcare provider must complete this form at the time of your physical. Upload **all 3 completed pages** to your CastleBranch account **and** to the Sacred Heart Student Health Portal using the following link: https://myhealth.sacredheart.edu/login_directory.aspx

Health Care Provider - please complete pages 1 & 2 – Student must complete page 3

1	**MMR Titer**		**One Time**
	1	Measles Titer (attach lab report – handwritten results are not accepted) Date: __/__/____	
		Results ☐Positive ☐Negative	
	2	Mumps Titer (attach lab report – handwritten results are not accepted) Date: __/__/____	
		Results ☐Positive ☐Negative	
	3	Rubella Titer (attach lab report– handwritten results are not accepted) Date: __/__/____	
		Results ☐Positive ☐Negative	
2	**Varicella Titer**		**One Time**
	Varicella Titer (attach lab report- handwritten results are not accepted) Date:__/__/____		
	Results ☐Positive ☐Negative **(Please note that history of chicken pox is not accepted)**		
3	**Hepatitis B - 3 doses and a Titer are required (attach lab report)**		**One Time**
	1st dose: __/__/____	2nd dose: __/__/____	3rd dose: __/__/____
	HEP B – BSAB = >10 (Quantitative Surface Antibody Titer) Result Date: __/__/____	Result ☐Positive ☐Negative (attach lab report - hand written results will not be accepted)	
4	**Tuberculosis – One of the following is required**		**Every year**
	A. Tuberculin skin test (Mantoux only) **Two step is required**		
	PPD Step 1 Planted: __/__/____ Step 1 Read: __/__/____ Result: ☐Positive ☐Negative PPD Step 2 Planted: __/__/____ Step 2 Read: __/__/____ Result: ☐Positive ☐Negative		**Provider's Initials:**
	PPD Step 3 Positive: ☐YES Chest X-Ray Date: __/__/____ **Attach radiology report of Chest x-ray results**		
	B. QuantiFERON Gold Blood Test: __/__/____	Results ☐Positive ☐Negative (attach lab results – hand written results will not be accepted)	
	If the results are positive, or the student has a history of a positive tuberculin skin test, a chest x-ray with normal findings, completed within the last 12 months, is required unless a history of INH therapy is documented. Repeat chest x-rays are not needed unless the student displays symptoms or signs of TB.		
5	**COVID-19 Vaccine - Due by July 15th (may be required annually if CDC guidelines mandate it)** **Official documentation must be attached, i.e., CDC Vaccination Card, VAMS Certification, etc.**		
	Vaccine Manufacturer: 1st dose: __/__/____ Booster: __/__/____	Vaccine Clinic Site Name: 2nd dose (if needed): __/__/____	

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6	**Tdap (Tetanus Vaccine)**	**Every ten years**
	Tetanus Diphtheria and Acellular Pertussis (TDAP):	
	Tdap Date (within last 10 years): ___/___/____	
7	**Influenza Vaccine - Due by October 15th (Must be for current year's flu season)**	**Every year**
	Influenza Vaccination Date): ___/___/____	
8	**Physical Exam Clearance**	**Every year**
	All students must have a physical exam every 12 months. Your healthcare provider should complete this physical exam form, sign/stamp it and date it in the appropriate section. An unsigned or undated form will be rejected.	

Healthcare Provider Acknowledgment:

I acknowledge that I have completed a physical exam and ordered the above required immunity testing for the student named above.

On the basis of my health assessment and physical exam, this student is cleared to participate in all activities, including clinical assignments in a health care setting, with no restrictions and has no known allergies.

(Please Check)☐ Yes ☐No
****If "no" is checked, please indicate any known allergies and/or restrictions/limitations below:**

Restrictions/Limitations (if any): _____

_____

_____

_____

_____

Allergies & Type of Reaction (if any): _____

_____

_____

Health Care Provider's Name:_____

Address: _____Phone:_____

_____ Date Signed: _____

Healthcare Provider's Signature

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9	**CPR Certification – Basic Life Support (BLS)**	**Must remain current**
	All students must have a current CPR Certification. Only two types are accepted: **American Heart Association – Healthcare professional CPR Basic Life Support (BLS Provider), or American Red Cross - Basic Life Support for Healthcare Providers**. You must upload your certificate of completion or eCard, showing the completion and expiration dates, to your CastleBranch account.	
10	**Background Check – Ordered through CastleBranch**	**One Time**
	All students must have at least one background check, which is ordered through CastleBranch upon creation of your account. Subsequent background checks may be required depending on the contract provisions of your clinical placement site.	
11	**Drug Testing – Ordered through CastleBranch**	**Every year**
	All students need to complete an annual drug test. Your initial drug screen will be ordered through CastleBranch upon creation of your account. Instructions on completing the drug screen are located in the TO-DO-LIST of your CastleBranch account. If you are starting in the Fall Semester, the drug screen must be completed between July 27th and August 4th. If you are starting in the Spring Semester, the drug screen must be completed between December 18th and December 31st. If the clinical site requires additional testing, you must comply. Instructions for your subsequent drug screenings will be sent to you at the end of the semester by the Compliance Coordinator.	
12	**Student Statement of Responsibility Section** All students must submit a Statement of Responsibility every year	**Every year**

Student Statement & Release

I understand that I must complete all requirements noted on this form, in addition to any other requirements of my clinical site, prior to participation in any clinical experience. **Initial**: _____

I am aware that if my health status changes in any way that would impact my ability to perform in any of the Programs at Sacred Heart University, I must notify the appropriate Program Director as soon as possible. I understand that the need for additional clearance will be determined at that time. **Initial:** _____

I hereby certify that the information provided in this form is true and accurate to the best of my knowledge and abilities, and I willingly release it to Sacred Heart University and their contracted partners, to be used solely in regards to my education and clinical placement through the University. This information will not be disseminated for any other purpose than that specified by myself, the applicant. By affixing my signature, I grant my full consent for release for the duration of my enrollment at Sacred Heart University. I am aware that I can revoke this consent, in writing, at any time. **Initial**: _____

Student Name (Print)_____Date_____

Student Signature_____Student ID _____