Nurse Assisting - Medical Clearance Form

Submit by December 1st

Student Name: _____ **DOB:**_____

Student Address: _____

Telephone Number:_____ **Email:**_____

Latex Allergy: _____ **Yes** _____ **No**

Allergies: _____

Medication & Supplements (List All) _____ **None**

_____

_____

Date of Exam *(must be completed within 6 months of clinical start date)*	**Height**	**Weight**	**Blood Pressure**	**Pulse**

Please circle findings. Comment only if abnormal.

Hand/skin: normal / abnormal

Comment: _____

Head/eyes: normal / abnormal

Comment: _____

Ears/nose/throat/mouth: normal / abnormal

Comment: _____

Neck/nodes: normal / abnormal

Comment: _____

Chest/lungs: normal / abnormal

Comment: _____

Cardio/vascular: normal / abnormal

Comment: _____

Abdomen: normal / abnormal

Comment: _____

Musculoskeletal/extremity/spine: normal / abnormal

Comment: _____

Nervous system/seizure disorder: normal / abnormal

Comment: _____

Genito/urinary: normal / abnormal

Comment: _____

Your Educational Partner of Choice BOCES 2 Center for Workforce Development

CWD Center for Workforce Development — Monroe 2-Orleans BOCES — Engage Educate Empower

Name: _____ Program: _____

IMMUNIZATIONS: Please indicate the date of Vaccination and Lot number or proof Titer

Administered Dates	#1	#2	#3	#4	Required or Optional?
MMR (Measles, Mumps, Rubella)	Date: Lot #	Date: Lot #			**REQUIRED**
Vacarella	Date: Lot #	Date: Lot #			**REQUIRED**
HEP B Vaccine (series)	Date: Lot #	Date: Lot #	Date: Lot #	Date: Lot #	**REQUIRED**
Sars-Cov-2 Vaccine	Date: Lot #	Date: Lot #	Date: Lot #	Date: Lot #	*Optional*
Influenza Vaccine (seasonal)	Date: Lot #				*Optional* ***highly recommended*** *(masking required if not complete)*
PPD SKIN TEST Date Placed:	Date Read:	Read By:	Lot #	Results:	**REQUIRED**

Positive PPD, chest X-ray results: (circle one): Normal / Abnormal **Date: _____**
(Mo/Day/Yr)

Does this patient suffer from any chronic physical or mental disabilities and or limitations that would interfere with patient care for a period of 6 hour to 12 hour working days? _____ Yes _____ No

If YES, please explain: _____

_____

To the best of my knowledge the above-named patient has been medically cleared to participate in clinical work and/or education at this time.

Physician's Name: _____ **NPI #:** _____
Print

Physician's Signature: _____ **Date:** _____
Sign

Physician's Office Stamp: