## City College First Year Health Clearance Process

STEP 1: Create an account and place your order.

STEP 2: Schedule an appointment for a Physical with your Physician/Local Urgent Care. Have the "Health Assessment Form" completed by a qualifying medical professional.

STEP 3: Schedule an Employer Drug Screening. Bring the code/form from your account to your scheduled appointment. Do not drink a lot of water in preparation for the appointment.

STEP 4: Upload all required documentation for Health Clearance to your account. For questions related to uploading documents, contact your account service directly. For all other questions related to clearance, e-mail clinicalclearance@citycollege.edu

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Dear Health Care Provider:

City College requires the following health clearance requirements from students:

1) **Medical History and Physical Exam**
   - Medical Professional must complete and sign the City College Health Assessment Form.
   - Student signature is required at the bottom of the form.
2) **Proof of Immunity** (titers) within the past 5 years:
   a. Measles
   b. Mumps
   c. Rubella
   d. Varicella
   e. Hepatitis B (note: Hepatitis B Surface Antibody **AND** Hepatitis B Surface Antigen lab results/titers required)
   f. Hepatitis C
3) **QuantiFERON Test**
   - For Tuberculosis – must be within 3 months
   - Blood test ONLY, (NO skin test/PPD is acceptable)
   - If results are positive, a chest x-ray within the past year is required.
4) **Immunizations**
   - Documentation of **Tdap** administered within the past 10 years.
   - Documentation of **Influenza** Vaccine administered for the current flu season
   - Note: If Hepatitis B Surface Antibody is negative, documentation of Hepatitis B vaccination is required.

**Summary of required lab reports with titers and reference ranges that must be submitted/uploaded along with the *Health Assessment Form to CastleBranch:***

1. Measles ab titers
2. Mumps ab titers
3. Rubella ab titers
4. Varicella ab titers
5. HBsAb (Hepatitis B Surface Antibody)
6. HBsAg (Hepatitis B Surface Antigen)
7. Hepatitis C Antibody
8. QuantiFERON TB-Gold

A student may be subject to additional clinical clearance requirements during their enrollment.
Students should upload all medical records to CastleBranch.com, as well as keep original documents on-hand for clinical sites.

# City College 1st Year Health Assessment Form

Student's Name:________________________________ Program:________________________________

Date of Birth:________________________________ Social Security #: XXX-XX-________________

**MEDICAL HISTORY**

Past Medical History: ________________________________________________

________________________________________________

Recent Illness (Detail): ________________________________________________

Allergies (including latex allergy): ________________________________________________

Current Medications (Details): ________________________________________________

________________________________________________

**PHYSICAL**

BP:__________Pulse:__________Temp:__________Weight:__________Height: __________

HEENT:__________Lungs:__________Heart:__________Abdomen:__________

Extremities:__________Neuro:__________Skin:__________

Comments: ________________________________________________

________________________________________________

________________________________________________

**ANTIBODY TITER/TB STATUS**

**Please attach official laboratory reports for the required tests:**

| | **Immune status** (circle one) | | **Official Laboratory Report Required** |
|---|---|---|---|
| **MMR:** | | | |
| Measles Ab (IgG) | + | - | ☐ Included |
| Mumps Ab (IgG) | + | - | ☐ Included |
| Rubella Ab (IgG) | + | - | ☐ Included |
| **Varicella (IgG)** | + | - | ☐ Included |
| **Hepatitis:** | | | |
| HBsAb (hepatitis B surface antibody) | + | - | ☐ Included |
| HBsAg (hepatitis B surface antigen) | + | - | ☐ Included |
| Hep C Antibody | + | - | ☐ Included |
| **QuantiFERON TB Gold** | + | - | ☐ Included |

If QFT Positive, CXR required (within one year prior to start date): Date:__________Results: Positive or Negative (Attach CXR Report)

**If vaccination required, please document below:**

| Vaccination | Date Administered | Lot number | Expiration da |
|---|---|---|---|
| MMR | | | |
| Varicella | | | |
| Hepatitis B #1 | | | |
| #2 | | | |
| #3 | | | |
| Influenza (current season) | | | |
| Tdap | | | |

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**PHYSICIAN OR HEALTHCARE**

I have examined the above named person and determined that they are free from evidence of any health impairment that would prevent them from participating in an allied health related clinical education program.

STAMP

Physician's Name:__________________Signature:________________________________

License Number:__________________Date: ________________________________

* Nurse Practitioner or Physician Assistant acceptable

**STUDENT**

I authorize the above named Physician/Nurse Practitioner/PA to complete this form in its entirety including my health history and medical records and to forward it to City College

Student's Name:__________________Student's Signature:__________________Date: __________