HEALTH STATUS REPORT

Completion of this document and all additional documentation is required to achieve clinical compliance.

The physical exam form must be filled out by a Health Care Provider, in **all areas** (student name and ID at the top of the form are the *only* exception) and signed by a Health Care Provider (Physician, Nurse Practitioner, or Physician Assistant).

- The physical examination form in this packet is **required**. No other documentation of a physical examination will be accepted. This must be signed by a Health Care Provider. The physical examination **must** be within 12 months of the last day of the term for which you are seeking clearance - **no exceptions**. This may require students to pay out of pocket if the expiration date falls outside of their insurance coverage window.
- Laboratory results with numeric lab values and reference ranges are required for all titers read. Please submit lab results, and/or vaccination records as supporting documentation. Titers that are in negative or equivocal range will require additional documentation showing a booster vaccine has been received. Titers must have beeen drawn no more than five years prior to the date of submission.
- If you require an accommodation or adjustment for the examination under the Americans with Disabilities Act, please contact our Accessibility Services office at ASC@excelsior.edu. For additional information, please visit: excelsior.edu/support-resources/accessibility-services.
- The Clinical Practice Experience Health Status Attestation on page 4 of this packet *must* be signed and uploaded along with your physical examination form.

NOTE: If you are updating your physical examination, you will need to have the signature of the Health Care Provider on the updated form. Any changes or corrections to the physical examination form must be signed, initialed, or stamped by the provider or the provider's office. Students may not make changes or corrections to a completed physical examination form. The only exception is the student name or ID number.

Acceptable Vaccine Records

NOTE: This is not a form. This is for reference only. Please do not complete and submit this as documentation.

Either	Or	Not Acceptable
MMR COMBINED VACCINE If born after 1/1/57, two (2) doses of LIVE vaccine: #1 no more than four (4) days prior to first birthday, #2 at least 30 days after first dose. OR **MEASLES** (2 doses required) Physician documentation of having the disease are acceptable in lieu of vaccine.	**MEASLES** Positive titre with numeric result and lab ranges, no more than 5 years old at the time of submission.	Titer older than 5 years not acceptable. Titer with only a positive or negative result not acceptable - MUST have numeric result and lab ranges. Quest Diagnostics recommended.
MUMPS (2 doses required) If born after 1/1/57, two (2) doses of LIVE vaccine given after first birthday. Physician documentation of having the disease are acceptable in lieu of vaccine.	**MUMPS** Positive titre with numeric result and lab ranges, no more than 5 years old at the time of submission.	Titers older than 5 years not acceptable. Titer with only a positive or negative result not acceptable - MUST have numeric result and lab ranges. Quest Diagnostics recommended.
RUBELLA (1 dose required) If born after 1/1/57, one (1) dose of LIVE vaccine given after first birthday.	**RUBELLA** Positive titre with numeric result and lab ranges, no more than 5 years old at the time of submission.	Titers older than 5 years not acceptable. Titer with only a positive or negative result not acceptable - MUST have numeric result and lab ranges. Quest Diagnostics recommended. **Documented history NOT ACCEPTABLE for Rubella.**
TETANUS/DIPHTHERIA **Titres not acceptable.** Must have proof of vaccination within last 10 years.	No other option available. Must be a vaccine/ booster that was administered no more than 10 years prior to the last day of the term for which you are seeking clearance.	Titers **not** accepable.
VARICELLA Two vaccines required.	**VARICELLA** Positive titre with numeric result and lab ranges, no more than 5 years old at the time of submission.	Titers older than 5 years not acceptable. Titer with only a positive or negative result not acceptable - MUST have numeric result and lab ranges. Quest Diagnostics recommended. **Documented history NOT ACCEPTABLE for Varicella.**
HEPATITIS B Series of three (3) vaccines	**HEPATITIS B** Positive titre with numeric result and lab, no more than 5 years old at the time of submission. OR Signed declination form (found on eValue Home Page)	Titers older than 5 years not acceptable. Titer with only a positive or negative result not acceptable - MUST have numeric result and lab ranges. Quest Diagnostics recommended.
ANNUAL TUBERCULOSIS SCREENING 2-step PPD (1-step PPD also accepted) Read date must be no more than 12 months prior to the last day of the term for which you are seeking clearance.	Documentation of BCG Vaccine OR QuantiFERON or T-Spot blood test showing negative result ** OR QuantiFERON or T-Spot blood test showing positive result with clear chest x-ray	PPD without date placed, date read, and results will not be accepted. Blood test result without a date the test was peformed is not acceptable. A note from a primary stating the BCG vaccine was received in the past without details of the vaccine is not acceptable.

Clinical sites have varied requirements regarding the time frame for QuantiFERON or T-Spot screenings for Tubercolosis. Tuberculosis screening is an annual requirement, so most require the screening be completed no more than 12 months prior to the last day of the term for which you are seeking clearance. Some clinical sites consider the blood screening to be valid for shorter periods of time. **If applicable, this will be indicated via an information sheet for the clinical site that can be found on the eValue Home Page.

EFFECTIVE DATE: 4/15/2019 Edited 8/15/2022, 1/2/2023, 5/18/2023, 7/27/2023, 9/1/2023

PHYSICAL EXAMINATION

All areas to be completed by health care provider or associate in provider's office (Student Name and ID are the only exceptions)

Date of Physical Exam: _____

STUDENT NAME: **STUDENT ID:**

Gender:	Blood Pressure:	Allergies:
Date of Birth:	Pulse:	
Height:		
Weight:		

CLINICAL EVALUATION (Check each item in proper column or enter **NE** if not evaluated)

System	Normal	Abnormal	Notes/Details
1. Neurologic			
2. Cardiac			
3. Respiratory			
4. Gastrointestinal			
5. Genitourinary			
6. Musculoskeletal			
7. Skin			

Additional Comments:

Clearance to care for patients across the life span: ☐ Yes ☐ No

Comments:

My signature confirms that I have examined the above named individual and found him/her to be in satisfactory physical condition to care for patients across the lifespan.

Signature of Heath Care Provider and Credential: _____

Name of Provider: _____ Phone: _____ Date: _____

(Print)

Clinical Practice Experience Health Status Attestation

Please read the below attestation and sign this page.

My signature verifies, to the best of my knowledge, that all the health data I have submitted is correct. I understand this information may be released to the clinical facility(s) where the graded activity is administered. If I encounter a change in my health status, I will notify Excelsior as soon as possible before my clinical practice exeperience.

_____

Print Name

_____

Signature

_____

Date