STUDENT HEALTH CERTIFICATION

Name: _____ ☐ Nursing/Clinical Student

Social Security Number _____ ☐ Research Scholar/Shadowing/Youth Student

Welcome to Lehigh Valley Health Network. We are vigilant about protecting you and our patients from infectious diseases. To ensure CDC recommendations for health care workers and LVHN policy are followed, you must provide documentation of the following immunizations and/or tests before beginning your experience at LVHN.

** Please note: **The documentation that follows must be provided by a healthcare professional capable of certifying that the following requirements have been met.** ****This form is valid for one year.**

To meet immunity requirements, must satisfy requirements in one column:
column A) required number of immunizations, or column B) physician documented history of disease or column C) positive titer

DISEASE	Column A IMMUNIZATION DATES			Column B DOCUMENTED HISTORY OF DISEASE	Column C IMMUNITY TITERS	
Required for All	Record Dates			Record Date	Date	Result of Titer
Varicella (chickenpox) 2 doses	(1)	(2)				☐ (+) ☐ (-)
MMR 2 doses after 1st birthday **OR:**	(1)	(2)				☐ (+) ☐ (-)
Measles (Rubeola) 2 doses after 1st birthday	(1)	(2)				☐ (+) ☐ (-)
Mumps 2 doses after 1st birthday	(1)	(2)				☐ (+) ☐ (-)
Rubella 1 dose after 1st birthday	(1)					☐ (+) ☐ (-)
Influenza (Required of all participating between October 1 until the end of flu season – end date to be determined annually based on local flu activity)	(1)					
Required for those who will have Patient Contact						
Hepatitis B vaccine - 3 doses	(1)	(2)	(3)			
Hepatitis C antibody titer	Negative	Positive*				
Must provide one of the following:						
Hepatitis B antigen titer	Negative	Positive*				
Documentation of a positive Hepatitis B antibody		Positive				
***Any positive result will be reported to Employee Health Services for review by expert review panel.**						
Recommended for all, not required.						
TDAP (Tetanus Diptheria Acellular Pertussis)	Date					

***Per CDC recommendations, 3 doses of Hepatitis B, 2 doses of varicella, and 2 doses MMR immunizations or documentation of disease are REQUIRED for proof of immunity.**

In order to protect our patients, staff and visitors, please review the following section carefully. If you or anyone in your household/family has shown any of the following symptoms/illnesses within three days of the program, **please refrain from participating until your doctor has released you to do so:**

vomiting	rash	conjunctivitis (pink eye)
cough	cold sore (fever blister)	cold or flu
strep infection	fever	Impetigo
diarrhea		

I hereby certify that_____ is free from communicable diseases in the communicable state. This individual does not possess any health handicap or other physical limitation which would interfere with his or her ability to satisfactorily perform the duties to which assigned within the scope of duties normally performed in the role identified above. I also certify that the immunization/immunity/testing requirements, as listed above, have been fulfilled.

Health Care Provider's Signature (required) _____

Health Care Provider's Name (print) _____

Phone number_____ Date _____

TUBERCULOSIS SCREENING QUESTIONNAIRE (required of any < 18 yr. old student)

If the student is still in high school, please answer the following questions. Circle yes or no for each question.

1. Does your child have any of the following: diabetes, kidney disease, or any immune deficiencies? **yes no**
2. In the past 5 years, has your child had contact with?
   - o Anyone who was told they had TB? **yes no**
   - o Anyone who was tested by the health department or their physician because they were suspected to have tuberculosis? **yes no**
   - o Anyone who is currently in jail or has been in jail during the last 5 years? **yes no**
3. Does your child currently have contact with anyone who is HIV infected, homeless? resident of a nursing home, user of illegal drugs or migrant farm worker? **yes no**
5. Did your family immigrate from or have lived for an extended period of time in Asia, Middle East, Africa, Latin America, Philippines and any of the Republics formerly known as the Soviet Union? **yes no**
6. Do you have foster children living in your home now or the in the past 5 years? **yes no**

_____ _____

Signature of parent/guardian completing the form Date

TUBERCULOSIS SCREENING REQUIREMENTS

(Required of any high school graduate or non-high school student over the age of 18)

In order for a high school graduate (student over the age of 18) to observe in any area of LVHN, two TB skin tests are required within 12 months prior to your observation; one test must be within 3 months of the observation date. Any test result dated before 12 months before you visit is not applicable. Document below the results of both TB tests, or attach relevant documentation. Note: Current high school students do NOT need to provide proof of TB tests unless specifically instructed to do so.

1. Previously positive TB test? ☐ Yes ☐ No If yes go to # 2. If no, either A or B must be fulfilled

A. TB skin testing: Two TB skin tests, one within 12 months, and one within 3 months prior to start of educational experience:

Date #1:____/____/____ Result ☐ (+) ☐ (-) Date #2:____/____/____ Result ☐ (+) ☐ (-)

***OR*:**

B. Quantiferon Gold Test within 3 months prior to prior to start of educational experience:

Date _____/____/___ Result _____

2. If previous history of a positive TB screening test:

Date of first positive TB skin test: ____/____/____ ☐ INH Therapy ☐ Yes ☐ No
Chest x-ray within the past 6 months: ____/____/____ Result ☐ nl ☐ abnl

TB testing can be administered at the location of the student's choice (i.e. private physician's office, school health center, or at any of the Health Works clinics listed above.) **LVHN does not provide TB tests for students.** The student is responsible for any and all charges.

Please complete/compile all forms and return to:

Office of Student Affairs,
Division of Education
1247 S. Cedar Crest Blvd., Suite #202
Allentown, PA 18103
Fax: 610-402-8402