Health Clearance Form for Visitors (page 1 of 2)

Name (First, Last) _____

Sex _____ Date of Birth ____/____/____

Home Address _____

_____

_____

Immunization

1) Measles, mumps, rubella, and varicella

Two doses are required. Please fill in the date (MM/DD/YYYY) of vaccine administration. Quantitative (not qualitative) IgG titers are also acceptable. Please attach a copy of the official laboratory printouts containing the numerical values for these titers with their reference ranges. If non-immune, please consult your physician to receive additional vaccines. If the titer is negative, at least one dose should be administered before you visit our facility.

	Date of the 1st dose	Date of the 2nd dose	OR	Titers (Date)
Measles	____/____/____	____/____/____		____/____/____
Mumps	____/____/____	____/____/____		____/____/____
Rubella	____/____/____	____/____/____		____/____/____
Varicella	____/____/____	____/____/____		____/____/____

2) Tdap (tetanus, diphtheria, acellular pertussis)

One dose after age 10 is required for anyone who is visiting the maternity, pediatrics, neonatal wards, and neonatal ICU.

Date: ____/____/____

3) Influenza

Only required when you are visiting between November and March.

Date: ____/____/____

4) Hepatitis B (optional)

Please fill in the date of vaccine administration and HBsAb titer if available.

1st: ____/____/____

2nd: ____/____/____

3rd: ____/____/____

HBsAb titer: _____ IU/L (Date: ____/____/____)

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Tuberculosis Clearance

Date of IGRA (Interferon Gamma Release Assays):_____/_____/_____

□ Negative □ Positive

If IGRA is positive, a chest x-ray and complete physical examination are required.

Please initial next to the following statement.

___ The individual above was free of symptoms suggestive of tuberculosis and his/her chest x-ray was negative.

Date: _____/_____/_____

Signature of Physician _____

Printed Name of Physician _____

Date _____

Name of Healthcare Facility _____

Address _____

Phone number _____