GALEN
MEDICAL GROUP

Wisdom. Compassion. Integrity.

Medical Clearance Form:

Required Immunization Documentation for Infectious Diseases Clearance
TB Screening
A. Two-Step Tuberculin Intermediate Skin Test (PPD) Test 1 Date: ___/___/___ Reading___/___/___ Results:_____ MM Induration: ___Neg ___Pos** Test 2 Date: ___/___/___ Reading___/___/___ Results:_____ MM Induration: ___Neg ___Pos** B. Chest X-Ray: Date: ___/___/___ Results:___ TB Symptoms: ___Neg ___Pos History of Treatment: ___Yes ___No If yes, Date: ___/___/___ How many months?:_____
Tdap Vaccine (tetanus, diphtheria, pertussis) * Recommended if working with pediatric practices.
Tdap Vaccine 1: ___/___/___
Flu Vaccine (Required only during flu season: September-April)
Flu Vaccine 1: ___/___/___
Hepatitis B (Direct Patient Care Contact Requires)
Hepatitis B: Surface Antibody Titer Date: ___/___/___ Numeric Value:____mlU/ml ___Neg ___Pos Hepatitis B Injection Dates: 1. ___/___/___ 2. ___/___/___ 3. ___/___/___
I HAVE EVALUATED THIS STUDENT AND HAVE FOUND THEM TO BE FREE FROM INFECTIOUS DISEASE. Provider Name: _____ Provider Signature: _____ Date: _____