HÔTEL-DIEU GRACE
ESTD HEALTHCARE 1888

Academic Placement Health Clearance Form

Section 1

FULL NAME:		PHONE NUMBER:	
FULL MAILING ADDRESS: (Street, City, Postal Code)			
DATE OF BIRTH:			

Section 2

To be filled out by a medical professional

Tuberculosis (TB) Mantoux Skin Test – 2 Step **PPD 0.1cc Intradermal – To be read 48 hours after test is administered**						
STEP 1	SITE	☐ RT Forearm ☐ LT Forearm	TIME GIVEN		DATE GIVEN	
	LOT #			EXPIRY DATE		
	MFR					
	GIVEN BY	(Print)		(Signature)		
	READ BY	(Print)		(Signature)		
	DATE READ		RESULT (mm)			
STEP 2	To be done minimum 7 days – maximum 4 weeks after Step 1 is completed					
	SITE	☐ RT Forearm ☐ LT Forearm	TIME GIVEN		DATE GIVEN	
	LOT #			EXPIRY DATE		
	MFR					
	GIVEN BY	(Print)		(Signature)		
	READ BY	(Print)		(Signature)		
	DATE READ		RESULT (mm)			
IF TB TEST WAS POSITIVE, A CHEST X-RAY IS REQUIRED						
DATE OF X-RAY			RESULT OF X-RAY			

COVID-19 Vaccination Requirements:		
PROOF OF 2 DOSES MINIMUM DATE COMPLETED		

Serology Testing:					
Please indicate Immune or Not Immune below					
MEASLES		MUMPS		RUBELLA	
VARICELLA		HEPATITIS B (with immunity level)			

Contact info of Medical Professional: (phone number or email address): _____

Signature or Stamp of Medical Professional: _____ **Date:** _____