



HÔTEL-DIEU GRACE  
ESTD HEALTHCARE 1888

Academic Placement Health Clearance Form

**Section 1**

Student Information

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

**Section 2**

To be filled out by a Physician

<b>Tuberculosis (TB) Mantoux Skin Test – 2 Step</b>						
PPD 0.1cc Intradermal – To be read 48 hours after test is administered						
<b>STEP 1</b>	SITE	<input type="checkbox"/> RT Forearm <input type="checkbox"/> LT Forearm	TIME GIVEN		DATE GIVEN	
	LOT #			EXPIRY DATE		
	MFR					
	GIVEN BY	(Print)		(Signature)		
	READ BY	(Print)		(Signature)		
	DATE READ		RESULT (mm)			
<b>STEP 2</b>	To be done minimum 7 days – maximum 4 weeks after Step 1 is completed					
	SITE	<input type="checkbox"/> RT Forearm <input type="checkbox"/> LT Forearm	TIME GIVEN		DATE GIVEN	
	LOT #			EXPIRY DATE		
	MFR					
	GIVEN BY	(Print)		(Signature)		
	READ BY	(Print)		(Signature)		
DATE READ		RESULT (mm)				
<b>IF TEST WAS POSITIVE, A CHEST X-RAY IS REQUIRED</b>						
DATE OF X-RAY		RESULT OF X-RAY				
<b>Serology Testing</b>						
DATE OF TESTING:						
Please indicate Immune or Not Immune below						
MEASLES		MUMPS		RUBELLA		
VARICELLA		HEPATITIS B (with immunity level)				

Signature of Physician or Health Professional \_\_\_\_\_ Date: \_\_\_\_\_

Address of Physician or Health Professional: \_\_\_\_\_