Center for Allied Health Education
First Year Health Clearance Process

STEP 1: Create a CastleBranch profile/account online by visiting https://portal.castlebranch.com/ND92

STEP 2: Schedule an appointment for a Physical with your Physician/ at a local Urgent Care. Have the "Health Assessment Form" completed by a qualifying medical professional.

STEP 3: Schedule an Employer Drug Screening with www.LabCorp.com. Bring the bar code from your CastleBranch account to your scheduled appointment. Do not drink a lot of water in preparation for the appointment.

STEP 4: Upload all required documentation for Health Clearance to your CastleBranch account. For questions related to uploading documents, contact CastleBranch directly. For all other questions related to clearance, e-mail clinicalclearance@cahe.edu

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Dear Health Care Provider:

Center for Allied Health Education (CAHE) requires the following health clearance requirements from students:

1) **Medical History and Physical Exam**
   - Medical Professional must complete and sign the CAHE Health Assessment Form.
   - Student signature is required at the bottom of the form.
2) **Proof of Immunity** (titers) within the past 5 years:
   a. Measles
   b. Mumps
   c. Rubella
   d. Varicella
   e. Hepatitis B (note: Hepatitis B Surface Antibody **AND** Hepatitis B Surface Antigen lab results/titers required)
   f. Hepatitis C
3) **QuantiFERON Test**
   - For Turberculosis – must be within 3 months
   - Blood test ONLY, (NO skin test/PPD is acceptable)
   - If results are positive, a chest x-ray within the past year is required.
4) **Immunizations**
   - Documentation of **Tdap** administered within the past 10 years.
   - Documentation of **Influenza** Vaccine administered for the current flu season
   - Documentation of **COVID-19** Vaccine administered, documented on a CDC Covid Vaccine Card
   - Note: If Hepatitis B Surface Antibody is negative, documentation of Hepatitis B vaccination is required.

Summary of required lab reports with titers and reference ranges that must be submitted/uploaded along with the *Health Assessment Form to CastleBranch:*

1. Measles ab titers
2. Mumps ab titers
3. Rubella ab titers
4. Varicella ab titers
5. HBsAb (Hepatitis B Surface Antibody)
6. HBsAg (Hepatitis B Surface Antigen)
7. Hepatitis C Antibody
8. QuantiFERON TB-Gold

A student may be subject to additional clinical clearance requirements during their enrollment.
Students should upload all medical records to CastleBranch.com, as well as keep original documents on-hand for clinical sites.

Center for Allied Health Education *Health Assessment Form - First Year*

Student's Name: ______________________ Program: ______________________

Date of Birth: ______________________ Social Security #: XXX-XX-____________

MEDICAL HISTORY

Past Medical History: ____

Recent Illness (Detail): ____

Allergies (including latex allergy): ____

Current Medications (Details): ____

PHYSICAL

BP:________ Pulse:________ Temp:________ Weight:________ Height: ________

HEENT:________ Lungs:________ Heart:________ Abdomen:________

Extremities:________ Neuro:________ Skin:________

Comments: ____

ANTIBODY TITER/TB STATUS

Please attach official laboratory reports for the required tests:

	Immune status (circle one)		**Official Laboratory Report Required**
MMR:			
Measles Ab (IgG)	+	-	☐ Included
Mumps Ab (IgG)	+	-	☐ Included
Rubella Ab (IgG)	+	-	☐ Included
Varicella (IgG)	+	-	☐ Included
Hepatitis:			
HBsAb (hepatitis B surface antibody)	+	-	☐ Included
HBsAg (hepatitis B surface antigen)	+	-	☐ Included
Hep C Antibody	+	-	☐ Included
QuantiFERON TB Gold	+	-	☐ Included

If QFT Positive, CXR required (within one year prior to start date): Date:____________ Results: Positive or Negative (Attach CXR Report)

If vaccination required, please document below:

Vaccination	Date Administered	Lot number	Expiration date
MMR			
Varicella			
Hepatitis B #1			
#2			
#3			
Influenza (current season)			
Tdap			
COVID-19			

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PHYSICIAN OR HEALTHCARE

I have examined the above named person and determined that they are free from evidence of any health impairment that would prevent them from participating in an allied health related clinical education program.

STAMP

Physician's Name:________________ Signature: ______________________

License Number:________________ Date: ______________________

* Nurse Practitioner or Physician Assistant acceptable

STUDENT

I authorize the above named Physician/Nurse Practitioner/PA to complete this form in its entirety including my health history and medical records and to forward it to Center for Allied Health Education.

Student's Name:________________ Student's Signature:________________ Date: ________