**SUNY Orange - HEALTH PROFESSIONS PROGRAMS**

**Change in Health Status Form**

Any student who has a change in their health status, while enrolled in the Health Professions Program, including the condition of pregnancy, must **resubmit medical clearance** from their health care provider (HCP), in order to remain in the clinical setting. *(Only this form will be accepted for change in health status)*

The submitted medical clearance must state that there are **no** medical conditions that will restrict the student from attending clinical, such as, but not limited to: lifting restrictions, caring for a specific type of an infectious client and/or disease due to a lowered immune system, or an infectious process the student may have developed that prevents contact with the patients.

**Section 1: PERSONAL INFORMATION**

PROGRAM:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEMESTER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_A#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last name First Name Date of Birth (MM/DD/YR)

Street Address City State ZIP

Phone number where you can be reached E-Mail address

Health Care Provider NAME Address Phone

**Section 2: DESCRIBE YOUR CHANGE IN HEALTH STATUS**  (To Be Completed by Student) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Section 3: REQUIRED EVALUATION FOR CLINICAL PARTICIPATION (**To Be Completed by HCP**)**

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| --- |
| * Is there loss or serious impairment of any paired organ? **( ) NO ( ) YES**
 |
| * Is there any limitation in normal activity? (e.g. Ability to walk, lift 35 lbs., (NIOSH, 2011)sit or stand for prolonged periods of time)

**( ) NO ( ) YES** If **“Yes”** clarify the nature of the limitation and the length of time you estimate it will exist, using specific dates: |
|  |
|  |
| * For the condition of PREGNANCY, are there any clinical restrictions? (e.g. Ability to walk, lift 35 lbs., sit or stand for prolonged periods of time.) **( ) NO ( ) YES** If **“Yes”** clarify the nature of the limitation and the length of time you estimate it will exist, using specific dates.
 |
|  |
|  |
| * Is there any limitation in caring for a client in the hospital setting in an isolation precaution room**? ( ) NO ( ) YES**
 |
| If **“Yes”** please explain nature of the limitation and the length of time you estimate it will exist, using specific dates. |
|  |
|  |

( **) YES**, I have performed a complete medical examination as indicated on the above named student and found to the best of my knowledge that he/she is free from physical or mental impairment which would impose a potential risk to: patients, self, others, or might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs, or “substances” which may alter the individual’s behavior.

( ) **NO**, the following active problems were identified which may interfere with the performance of his/her duties:

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Signature and STAMP of Examining Physician, Nurse Practitioner, or Physician’s Assistant

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Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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10/4/16