MEDICAL FORMS FOR CLINICALS
for
Non-Credit Allied Health Students participating in Clinical Activities

COMPLETED FORM IS DUE ON OR BEFORE

PLEASE MAIL OR HAND DELIVER COMPLETED FORM TO:

Your Primary Instructor

Norwalk Community College
188 Richards Ave.
Norwalk, CT 06854
TO THE EXAMINING PHYSICIAN/HEALTHCARE PROVIDER: Date of Exam: ___________ (within 12 months of start of program)
On the basis of my health assessment and physical exam:

☐ yes  ☐ no   STUDENT IS CLEAR TO PARTICIPATE IN CLINICAL COURSES WITH NO RESTRICTIONS (please check)
IF NO, please explain the nature of the restrictions/limitations related to the delivery of patient care:
___________________________________________________________________________________________________________

☐ Student denies Latex Allergy

IMMUNIZATION ASSESSMENT:

TITERS MUST BE POSITIVE PER LABORATORY STANDARD; REPORT MUST ACCOMPANY THIS FORM. If titers show student is not immune, please state plan of how non-immunity will be addressed:

TETANUS/TD BOOSTER: ________________ (must be within last 10 years)

RUBEOLA (MEASLES) TITER ___________________ Immune? Yes ______ No _______ (if no, include plan)
May be Qualitative or Quantitative Titer Laboratory report must be attached

RUBEOLA TITER (GERMAN MEASLES) ___________________ Immune? Yes ______ No _______ (if no, include plan)
May be Qualitative or Quantitative Titer Laboratory report must be attached

MUMPS TITER: ___________________ Immune? Yes ______ No _______ (if no, include plan)
May be Qualitative or Quantitative Titer Laboratory report must be attached

VARICELLA (CHICKEN POX) TITER: ___________________ Immune? Yes ______ No _______ (if no, include plan)
May be Qualitative or Quantitative Titer Laboratory report must be attached

ANNUAL ASSESSMENTS/REQUIREMENTS:

Hep. B SERIES:
Per protocol 1st dose  2nd dose  3rd dose

Hep. B Surface Antibody Titer ___________________ Immune? Yes______ No______ (if no, include plan)

>10milU/ml is positive/Immune  2 months following the last dose Laboratory report must be attached

PPD 1 (Mantoux Tuberculin testing required yearly) (Unless requirements of clinical facility differ) Date Given Date Read Results

If positive PPD, list chest x-ray date: ___________________ ☐ Student shows no evidence of TB symptoms

If positive PPD, list chest x-ray date: ___________________

Influenza Vaccination is highly recommended for students in a program during Influenza season __________________

Influenza Vaccine is medically contraindicated for this student _________ date given

Healthcare Provider Print Name Healthcare Provider Signature DATE

Address: ______________________________ Telephone (___ ) ______ - ________
Addendum to HEALTH ASSESSMENT FORM
for
Students participating in Clinical Activities with Positive PPD and Negative Chest x-ray

Student Name __________________________________ Date of Birth __________________________

Survey questionnaire – To be completed by student if PPD is positive

Have you experienced any of the following in the past year:

1. Night sweats? Yes____ No_____
2. Persistent low grade fever? Yes____ No_____
3. Cough that has lasted more than 1 month? Yes____ No_____
4. Unexplained weight loss? Yes____ No_____
5. Fatigue Yes____ No_____
   If yes, to what do you attribute this? ___________________________

6. Have you had any other symptoms? Yes____ No_____
   If yes, please describe ______________________________________

7. Have you lived or visited abroad in the past year? Yes____ No_____
8. Have you been in contact with anyone who has had TB? Yes___ No____

Student Signature______________________________________________

☐ Student shows no evidence of TB symptoms

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<tr>
<th>Healthcare Provider Print Name</th>
<th>Healthcare Provider Signature</th>
<th>DEA Number</th>
<th>Date</th>
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Address __________________________ Telephone __________________________

Revised May 2011
Information for Students and Healthcare Providers about Immunity Assessment/Titers for Healthcare Provider Students


Tetanus/Diphtheria/Pertussis (Td/Tdap): All adults who have completed a primary series of a tetanus/diphtheria-containing product (DTP, DTaP, DT, Td) should receive Td boosters every 10 yrs. For adults younger than 65 yrs, a 1-time Tdap is recommended to replace the next Td.

MMR: the MMR titers once determined do not have to be rechecked, regardless of when drawn. It is possible that they may be lowered during pregnancy, but otherwise should remain consistent. In this case a qualitative titer is acceptable. In a situation whereby a student was vaccinated with 2 doses of MMR vaccine within the past 12 months, no other documentation is necessary.

Varicella: Qualitative or Quantitative titers should be drawn once; if immunity is determined to be present then student does not need titer drawn for subsequent years. In a situation whereby a student was vaccinated with 2 doses of Varicella vaccine within the past 12 months, no other documentation is necessary.

Hepatitis B: Some people NEVER develop immunity; some can lose immunity over time, thereby requiring a booster. So with this in mind:

- those students that go through their series of injections during or in preparation for year one of the program, should then go on to have a QUANTITATIVE test for year 2 (Nichols number is: 51938P, apparently a classification system for labs). This value must exceed 10 milliunits/ml to establish immunity. If immunity is not established, the student should have a booster and have immunity rechecked.
- If a student produces a recent titer (less than 5 years old) that establishes immunity this will suffice for at least two years. In the event that a student produces a titer 5 years or older a quantitative titer is required for year 1.
- If a student produces documentation of completion of the Hep B series according to proper immunization schedule, (2nd dose in 30 days, and 3rd dose in 180 days), given 5 years ago or older; dates of immunization are considered sufficient.
- If a student refuses to receive immunization for Hepatitis B despite counseling in favor of it, a waiver must be signed and kept on file.

PPD: The general standard for the majority of affiliates is a “one step” ppd. On occasion, clinical affiliates require a “two step” ppd, thus students affiliating at this facility must then be in compliance. It is felt at this time that this requirement is not widespread enough to make it the standard. All ppds must be updated on a yearly basis in order to maintain status in the program, exceptions:

- Students who have received BCG immunization should not get a PPD
- Students who have had a positive PPD
- Students who are immuosuppressed, have cancer, or are on steroids should not get a PPD

If PPD cannot be obtained because of the above, student should have a SINGLE chest x-ray to document freedom from disease. Thereafter, on a yearly basis, a note must be received from the Healthcare provider stating that the student shows no evidence of symptoms of TB

Influenza Vaccination: all healthcare workers should receive annual influenza vaccination Trivalent (Inactivated) Influenza Vaccine (TIV) may be given to anyone; Live, Attenuated Influenza Vaccine (LAIV) may be given to non-pregnant healthy persons age 49 years and younger (CDC, 2008). Exceptions made only for those students for whom their HCP states the vaccination is medically contraindicated.

Student Statement of Responsibility

I understand that I must submit a completed Health Assessment form prior to participation in any clinical experiences.

I am aware that if my health status should change in a way that would impact my ability to perform in the nursing program, I must notify the Director/Administrator of the program immediately. The need for additional clearance will be determined at that time.

_____________________________
Student Name (Please Print)

______________________________ __________________
Student Signature Date