Norwalk Community College
188 Richards Ave.
Norwalk, CT 06854

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

Norwalk Community College
Non-Credit Allied Health Programs

Student Name _____ **ID#**_____ **Date of Birth**_____

Address _____ **City** _____ **State** _____ **Zip** _____

Student Phone _____ **Student e-mail**_____

Emergency Contact Name_____ P**hone Number**_____

Program Student Entering _____ **Program Start Date** _____

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)
date given

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

RUBELLA 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)
≥ 10mlU/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 facilty differ) Date Given Date Read Results

If positive PPD, list chest x-ray date: _____ ☐ Student shows no evidence of TB symptoms
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** ( ) _____ - _____

Norwalk Community College
Non-Credit Allied Health Programs

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**

_____ _____ _____ _____
Healthcare Provider Print Name **Healthcare Provider Signature** **DEA Number** **Date**

_____ ( ) _____-_____
Address **Telephone**

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

Refer to the CDC Healthcare Personnel Vaccination Recommendations www.immunize.org/catg.d/p2017.pdf

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, (2^{nd} 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.

References: Center For Disease Control http://www.immunize.org/catg.d/p2017.pdf, http://www.nfid.org/influenza/professionals_workersflu.html, http://www.nfid.org/HCWtoolkit/, http://www.nfid.org/HCWtoolkit/CSLToolkitDocument.pdf; Quest Diagnostic Laboratory, 2004

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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