Health Science Immunization & Physical Examination Requirements

All Health Sciences students taking classes with a clinical rotation **must** submit a Health Sciences **Immunization Form** (page 2), **Influenza (FLU) Vaccine Form** (page 3), **Tuberculosis Screening Form** (page 5), **Physical Form** (page 6). All forms must be signed by a physician/ARNP/PA (with clinic stamp) to document all physical and immunization requirements.

The cost for the physical and immunizations/titers are the responsibility of the student. The Health Sciences Department will not make any arrangements for the services to be completed.

All four (4) forms listed above must be submitted to your Clinical Liaison appointee. Deadlines for final submission will be provided during orientation**. Failure to comply with the Clinical Liaison Office deadline will result in the student not being able to attend clinical rotations and completing the program.** The Health Sciences Department will not refund tuition fees for non-compliance.

REQUIRED ANNUALLY

Tuberculosis Screening Form	Influenza Vaccine Form	Physical Exam Form
You must have proof of a: Negative PPD (Mantoux) skin test **OR** Negative/Non-reactive QuantiFERON blood test If the above are positive/reactive you must get a: Chest X-ray **AND** Tuberculosis Symptom Screening Questionnaire	**You must get the Influenza (Flu) vaccine/shot/mist every flu season** Medication name, date, lot number, expiration date and arm injected (left/right) must be documented. The flu season starts every year on September 1 and ends the following March 31. The 2018-19 flu vaccine does not work for the 2019-20 season.	A physical examination must be completed every year.

REQUIRED (one time)

Immunization Form			
Hepatitis B	**Tdap**	**Varicella (Chickenpox)**	**MMR**
You must have proof of: three (3) vaccines **OR** Positive titer/blood work The three (3) vaccine series can take 7 months to complete. If titer is negative, you must get the three (3) vaccines, or two (2) vaccines with a physician/ARNP/PA's note.	Tdap stands for Tetanus, Diphtheria, and Pertussis. You must have proof of one (1) Tdap vaccine within the last ten (10) years. TD vaccines are not accepted.	You must have proof of: Two (2) vaccines **OR** Positive titer/blood work If titer is negative, you must get the two (2) vaccines, or one (1) vaccine with a physician/ARNP/PA's note. The two (2) vaccine series takes 1 month to complete. A note from a physician/ARNP/PA stating you have a history of chicken pox and only need one (1) vaccine is accepted as well.	MMR stands for Measles, Mumps, and Rubella. You must have proof of: Two (2) vaccines. **OR** Positive titer/blood work. If titer is negative, you must get the two (2) vaccines, or one (1) vaccine with a physician/ARNP/PA's note. The two (2) vaccine series takes 1 month to complete.

Note: Students have the right to decline vaccination but are not likely to be able to attend mandatory clinical rotations. **Students who do not attend all required clinical rotations will not be able to complete their program of study.**

Immunization Requirements Form
To Be Completed by Provider Only

Student Full Name: _____ Date of Birth (month/day/year): ____/____/_____

To the healthcare examiner: Please complete and sign EACH section below. You are attesting each section signed by you is accurate and that records exist proving the student has received the vaccines OR has positive titers.

✱ **Tdap** (Must be within the past ten (10) years): Date administered: ____/____/____		
Provider's Attestation Signature:_____ License #_____		
✱ **Varicella** (Must have received two (2) doses OR a positive titer)	1st dose: ____/____/____	2nd dose: ____/____/____
Titer Date: ____/____/____ Titer Results: ☐ Positive ☐ Negative		Provider's Attestation Signature: _____ License #_____
✱ **Measles, Mumps, Rubella (MMR)** (Must have received all MMR doses OR a positive MMR titer)		
Measles**	1st dose: ____/____/____	2nd dose: ____/____/____
Titer Date: ____/____/____ Titer Results: ☐ Positive ☐ Negative _____(value) per _____ (unit)		Provider's Attestation Signature: _____ License #_____
Mumps**	1st dose: ____/____/____	2nd dose: ____/____/____
Titer Date: ____/____/____ Titer Results: ☐ Positive ☐ Negative _____(value) per _____ (unit)		Provider's Attestation Signature: _____ License #_____
Rubella	One dose: ____/____/____	
Titer Date: ____/____/____ Titer Results: ☐ Positive ☐ Negative If negative MUST get at least one (1) vaccine _____(value) per _____ (unit)		Provider's Attestation Signature: _____ License #_____
✱ **Hepatitis B** (Must have three (3) vaccines OR a positive titer**)		
Three (3) Vaccines Dates:	1st dose: ____/____/____	2nd dose: ____/____/____ 3rd dose: ____/____/____
Titer Date: ____/____/____ Titer Results: ☐ Positive ☐ Negative _____(value) per _____ (unit)		Provider's Attestation Signature: _____ License #_____

** **If negative MUST receive two (2) vaccines, or one (1) vaccine with provider's note saying it is safe for you to attend clinicals****

Examiner Stamp (include address and phone)

_____

_____

Influenza (FLU) Vaccine Form

The Influenza (FLU) vaccine is annual and is required unless you have a medical reason.
The FLU season starts every year on September 1st and ends the following March 31st

Example: September 1 to March 31. The 2018-2019 flu vaccine will no longer be valid starting April 1, 2019. You must get the 2019-2020 flu vaccine in late August 2019.

TO HEALTH PROVIDERS: Please fill out ALL sections completely.

Student Full Name: _____Date of Birth (month/day/year): ____/____/____

Influenza vaccine (September 1 – March 31)

Date administered: ____/____/____

Route: ☐ IM ☐ SQ

Expiration Date: ____/____/____

Site Given (select one):
☐ Right Deltoid ☐ Left Deltoid
☐ Right Gluteus ☐ Left Gluteus
☐ Right Nostril ☐ Left Nostril

Lot #: _____

By signing below I *attest that records exist proving this student received the most current season's Influenza vaccine.*

Provider's Signature: _____ Date: _____

Clinic/Pharmacy Name: _____ Professional License #_____

Address: _____

Phone Number: (_____)_____-_____

Examiner Stamp / Pharmacy Sticker

Health Sciences Tuberculosis (TB) Screening Form

The Tuberculosis Screening is ANNUAL. This form must be submitted every year

Student Full Name: _____ Date of Birth (month/day/year): ____/____/_____

Students: You may select from one of the following: **2-step** TB skin test (PPD) **-OR-** QuantiFERON (QFT)/T-Spot test

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Health Examiner: Please fill out all sections of this form carefully & completely

☐ History of BCG vaccine? **No** ☐ **Yes** ☐ **Last BCG vaccine date: ____/____/____**

PPD #1	**PPD #2 (Placed 1-3 weeks after PPD #1)**
Date given: _____	Date given: _____
Amount: _____	Amount: _____
Lot#: _____	Lot#: _____
Exp. Date: _____	Exp. Date: _____
Manufacturer: _____	Manufacturer: _____
Arm Site: _____	Arm Site: _____
Administered by: _____	Administered by: _____
Date Read: _____	Date Read: _____
Result: _____ Positive OR _____Negative	Result: _____ Positive OR _____Negative
Name of Reader:_____	Name of Reader:_____
Professional License #_____	Professional License #_____

OR

	Date of Draw	**Result:**	**Analyte Results:**
QuantiFERON/ T-Spot	____/____/____	☐ Reactive -OR- ☐ Non-Reactive	_____(value) per _____ (unit)

STOP and READ

The next section is required to be completed **only** if:

Your PPD test was positive **OR** Your QFT was reactive

Chest X-ray	**Date:**	**Location:**	**Result:**	**Are both lungs clear?**
Valid for 5 years With ANNUAL TB Questionnaire	____/____/____	Name:_____ Address:_____ _____ _____	☐TB Negative -OR- ☐TB Positive	☐Yes -OR- ☐No
Name of Examiner_____		Professional License #_____		

Health Sciences Tuberculosis (TB) Symptom Screening Questionnaire

COMPLETE ONLY IF YOU HAVE A CHEST X-RAY

The Tuberculosis Screening is annual. This form must be submitted every year.

Student Full Name: _____ Date of Birth (month/day/year): ____/____/_____

PART A – Questionnaire to be filled by student.

1. Have you experienced any of the following symptoms in the past year?

a). Productive cough for more than 3 weeks?	Yes___ No___
b). Hemoptysis (coughing up blood)	Yes___ No___
c). Unexplained weight loss?	Yes___ No___
d). Fever, Chills, or night sweats for no known reason?	Yes___ No_
e). Persistent shortness of breath?	Yes___ No___
f). Unexplained fatigue?	Yes___ No___
g). Chest Pain?	Yes___ No___
h). Recurrent Kidney or bladder infections?	Yes___ No___
i). Swollen glands usually in the neck?	Yes___ No___
j). Recent diagnosis of diabetes?	Yes___ No___

2. Have you had contact with anyone with active TB disease in the past year? Yes___ No___

3. Do you have medical condition or take medications that suppress your immune system? Yes___ No___

4. Why are you required to have a TB skin test? _____

I, _____(Printed Student Name) *declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge.*

Student Signature: _____ Date: _____/_____/_____

PART B – To be filled by provider.

Upon review of the TB results, responses to the questionnaire (if applicable) and the discussion with the person for whom the tuberculosis evaluation is required, I recommend as follows:

- ☐ There is no indication this person has active tuberculosis at this time.
- ☐ Further evaluation including Interferon Gamma Release Assay or other medical evaluation is indicated and should be completed prior to work placement or admission to a clinical site.

CLINIC/ORGANIZATION STAMP with ADDRESS

Printed Provider Name: _____

Provider's License Number: _____

Provider's **Signature**: _____

Date: _____/_____/_____

Health Sciences Physical Exam Form
TO BE FILLED BY PROVIDER ONLY

Health Examiner: Please ease complete this physical form. This form must be signed by a licensed health care professional (Physician/ARNP/PA).

Student's Full Name:	Date of Birth (month/day/year):
Course Name:	
The student may participate in clinical experience that includes an invasive procedure such as phlebotomy. Is the **student** free from communicable disease(s) in order to work in this capacity? (choose one) ☐ Yes ☐ No (Please explain):	

✱ Please acknowledge by checking Y□ or N□ the student perform essential functions and meets standards for clinical courses without harm to self/others, including:

Environmental Conditions:		**Clinical Tasks and Skills:**	
Potentially be exposed to blood borne pathogens	Y□ N□	Has fine motor manipulation of hands and fingers	Y□ N□
Potentially be exposed to infectious pathogens	Y□ N□	Fit and use personal protective equipment	
Work with latex, chemicals, water and detergents	Y□ N□	Use latex protective gloves and N-95 respirator	Y□ N□
Work alone or in groups	Y□ N□	mask	Y□ N□
		Work irregular hours and different shifts	
	Y□ N□		Y□ N□
Physical Requirements:		**Sensory and Cognitive Requirements:**	
Carry, lift, push and pull 50-75 pounds	Y□ N□	Has binocular vision. (Check if monocular □)*	Y□ N□
Has gross motor skills to manipulate equipment	Y□ N□	Has near and far vision (Uncorrected/Corrected)*	Y□ N□
Assist in transferring and lifting patients	Y□ N□	Has 20/20 vision (Uncorrected/Corrected)*	
Frequently reach, grab, grasp	Y□ N□	Has no color vision deficiency	Y□ N□
Frequently twist, bend and reach overhead	Y□ N□	Hear (Whisper test at twelve (12) feet)	Y□ N□
Frequently rotate trunk	Y□ N□	(Check if hearing-aid needed □)*	Y□ N□
Work seated and standing for minutes to hours	Y□ N□	Multi-task	
Occasionally climb less than six (6) feet	Y□ N□	Communicate clearly by speech	Y□ N□
Occasionally stoop and kneel	Y□ N□	Has ability to reason, make calculation, analyze	Y□ N□
		Function in high stress and complex situations	Y□ N□
			Y□ N□

As the examiner, I attest (please check one)**:**

☐ The student meets the essential physical and mental standards noted above for participation in a health care setting.

☐ The student will require the accommodations or restrictions to participate in a health care setting.
Accommodations/Restrictions are: _____.

☐ The student does not meet the essential physical and mental standards noted above, and is not able to participate in

Physicals are required every year; this physical is expires in one year from today's date: ____/____/_____

Examiner's **Printed Name:** _____

Examiner's **Signature:** _____

Professional License # _____

Examiner Stamp