

# Student Health Form

## Howard Community College Health Science Division

Check program:

Nursing:

Fall: PN\_\_ RN\_\_

Spring \_\_\_\_

Accelerated \_\_\_\_

CVT: \_\_\_\_

EMT: \_\_\_\_

Radiology: \_\_\_\_

**Students: Please complete all sections of this form and return completed forms to Health Science Division Office ST-149**

Name: \_\_\_\_\_ HCC ID# \_\_\_\_\_

Have you completed the following **REQUIREMENTS**?

### Checklist:

- Vaccinations:** MMR \_\_\_\_ Varicella \_\_\_\_ Hepatitis B \_\_\_\_ Tetanus \_\_\_\_
- Titres:** MMR \_\_\_\_ Varicella \_\_\_\_ Hepatitis B \_\_\_\_  
If you have no immunity for the vaccinations, you must submit proof of boosters received.
- Tuberculosis (need yearly):** PPD \_\_\_\_ TB Form \_\_\_\_ Chest X-ray \_\_\_\_  
(Report required if positive PPD test)
- CPR: American Heart Association: Basic Life Support for Health Care Providers** \_\_\_\_  
(Only accepted class) OR successful completion of HEED-112
- Criminal Background Check:** \_\_\_\_ **Receipt of payment to Pre-check** \_\_\_\_  
(Follow instructions and complete according to dates stated. If you complete too early, you will have to re-submit)
- Make a copy of this form for your records** \_\_\_\_\_

### Deadlines:

#### Nursing Students

- Summer Admission April 10
- Fall Admission July 10
- Spring Admission December 10
- NURS-099 Complete Health Form 2 weeks before the start of class

#### EMT-P Students

- Complete Health Form September 20

#### CVT Students

- Complete Health Form February 1

#### Radiology Students (Summer 2008)

- Complete Health Form April 10

### Questions:

Tanya Icaza , RN, BSN

Clinical Coordinator

Phone: 410-772-4028

E-mail: [ticaza@howardcc.edu](mailto:ticaza@howardcc.edu)

Hours: Tue., Wed., Thurs., 10 a.m. – 5 p.m.

Meg Tricoli, RN BSN

Clinical Coordinator

Phone: (410) 772-4204

E-mail: [mtricoli@howardcc.edu](mailto:mtricoli@howardcc.edu)

Hours: Mon., Wed., Fri. 8:30 a.m.-3:30 p.m.

Office: N 223  
Fax: (410) 772- 4494

**SECTION I:**

**Name:** \_\_\_\_\_  
Last First Middle Initial

**Address:** \_\_\_\_\_  
Street  
\_\_\_\_\_  
City State Zip Code

**Phone:** \_\_\_\_\_  
Home Cell

**HCC ID#:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**In Case of Emergency (ICE) Contact:**

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Phone : \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**\*\*\*Please enter the emergency contact person's name and phone number into your cell phone, type ICE before their name. This will alert faculty and EMS to contact this person in the event of illness or emergency to the HCC student.**

**IMPORTANT**

- The following sections **MUST** be completed by a licensed health care provider
- **DO Not** submit this form until it is **100%** complete
- Late health forms may result in **Forfeiture of Seat**
- The **Physician or Nurse Practitioner's** signature is required on this form
- \*Student signatures are required under **Hepatitis Vaccination/Waiver** and under **Health Sciences Policies** on this form
- **DO NOT COMPLETE CRIMINAL BACKGROUND CHECK BEFORE:**
  - **Summer 2008:** March 3, 2008
  - **Fall 2008:** June 2, 2008
  - **Spring 2009:** November 6, 2008

**SECTION II: Vaccinations and Immunity Status (To Be Completed by Licensed Health Care Provider)**

**Measles, Mumps, and Rubella (MMR):**

**Titre:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If MMR Titre indicated insufficient immunity, the booster is required.

**Booster:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Varicella:**

**Titre:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If Varicella Titre indicates insufficient immunity, then booster is required.

**Booster:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Tetanus:**

**Date of Vaccine:** \_\_\_\_\_

**If last vaccine was 8 years ago or longer, a TDAP vaccine must be given (new guidelines)**

**TDAP:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Hepatitis B (HBV):**

**Date(s) of Vaccine:** 1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

**Titre:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Hepatitis B Surface Antibody Quantitative Titre is the only test accepted for immune status. If HBV Titre indicates insufficient immunity, then booster is required.**

**Booster:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Hepatitis B Vaccination, Verification and Waiver**

Check the appropriate statement and attach written proof of vaccine and immunity status:

- \_\_\_\_\_ I have completed the Hepatitis B vaccination series and have proof of immunity from a blood titre test. (**Submit documentation**)
- \_\_\_\_\_ I have completed the Hepatitis B vaccination series and have decided not to receive a Hepatitis B booster vaccination at this time.
- \_\_\_\_\_ I am in the process of obtaining the series of 3 Hepatitis B vaccinations. (**Submit documentation**)
- \_\_\_\_\_ I have decided not to receive the Hepatitis B vaccination series at this time. I understand that this choice will put me at risk for acquiring Hepatitis B. *I accept full responsibility for the consequences of my decision.*

I have read the Hepatitis B Fact sheet and understand that this infection is potentially life threatening. I understand that due to exposure to blood, body fluids, and potential infective material during my clinical experience, I may be at risk of acquiring the Hepatitis B virus (HBV) infection. I have discussed this with my health care provider and have checked the appropriate statement above.

\_\_\_\_\_  
**\*Student Signature**

\_\_\_\_\_  
**Date**

**SECTION III. Tuberculosis**

**(To Be Completed by Licensed Health Care Provider)**

All students entering the HCC Health Science Division programs must have a documented PPD skin test. Students with a history of a positive PPD skin test or BCG vaccination should submit a Chest X-ray report and complete the Tuberculosis Questionnaire. **All students are required to provide continuous documentation by submitting proof of status at the beginning of each semester, clinical rotation, and/or whenever requested.**

**Part I. PPD Skin Test**

Date of PPD Skin Test: \_\_\_\_\_ Date Read: \_\_\_\_\_ Results: \_\_\_\_\_

**Part II. If PPD Skin Test is Positive**

Date of Chest X-Ray: \_\_\_\_\_ Report: \_\_\_\_\_

**Part III. Tuberculosis Questionnaire Form**

A Licensed Health Care Provider must complete this form. This Questionnaire is to be utilized if the student has a positive PPD Skin Test and the health care provider feels a Chest X-ray is not necessary for the yearly follow-up.

<b>Tuberculosis Questionnaire</b>	<b>Yes</b>	<b>No</b>
Does the student have a fever?		
Does the student get tired easily?		
Does the student have any Chest Pain or Shortness of Breath?		
Is the student experiencing any chills or night sweats?		
Has the student had any loss of appetite?		
Has the student has any sudden unexplained weight loss?		
Has the student had a productive or prolonged cough lasting > 3 weeks?		
If the student has a cough, are they spitting up blood?		

**Attach All Current Vaccination, Titre, and Booster Lab results to the last page of Health Form, or this form will not be accepted.**

**Section IV. Health Care Provider Recommendations and Signature**

I have given the Student: \_\_\_\_\_, a complete history and physical exam and I consider the student mentally and physically able to participate in the Howard Community College Health Science program.

Provider's Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_

**Signature of Licensed Health Care Provider:** \_\_\_\_\_

## Howard Community College Health Science Division Policies

**1. Health Status Change for All Students:**

Any student experiencing a change in health status, including pregnancy, while enrolled at HCC will be required to submit a written statement from his/her health care provider as to the student's ability to perform all expected functions fully, safely, and without jeopardizing the health and/or well being of the student or others. Pregnant students must submit a written statement from their health care provider prior to registering for classes each semester. The documentation must state the student's ability to perform all expected functions fully, safely, and without jeopardizing the health and well being of the student, fetus, and/or others. After delivery, the student must submit a written release statement from the health care provider. The release of care must be presented prior to resuming classes and clinical.

**2. Continuous Verification of CPR Certification and TB Status:**

Students are required to submit documentation of their CPR certification and TB status prior to the start of clinical rotation or whenever requested. It is the student's responsibility to update and maintain their health records.

**Verification of CPR certification and the absence of TB are required for clinical.**

**3. Notification regarding the Small Pox Vaccine:**

Students will not be allowed to attend clinical for 28 days after receiving the Small Pox vaccine and the inoculation site must be completely healed. Students must notify the Health Science Division of small pox vaccine status. **Note:** This vaccine is not required for admission into any of the Health Science Division clinical rotations.

**4. Health Insurance:**

Howard Community College does not provide or sponsor health insurance to the students. HCC does have a resource list of various companies that provide health insurance. Students can pick up health insurance pamphlets in Admissions, Student Life, and the Wellness Center. In the event that a student sustains an injury while on campus or in clinical, it is the responsibility of the student to utilize their own health insurance plan to cover the cost of treatment and/or follow up care. **Students are strongly encouraged to obtain their own health insurance policy as Howard Community College will not cover student health care costs.**

**5. Liability Insurance**

As a student in the Health Sciences Division at Howard Community College, you will be covered by the college's Liability Insurance while you are attending approved clinical activities arranged by the Health Sciences Division faculty. The liability insurance provides for legal expenses, to the limits specified by the coverage, in the event a student is sued by a patient for malpractice or negligence. A student will be eligible for liability coverage only if acting within the scope of practice abilities and were being appropriately supervised at the time the incident occurred. **Note: Liability Insurance is not Health Insurance.**

**6. Essential Functions**

All students are to adhere to Essential Functions guidelines.

I have read and understand the policies listed above:

\_\_\_\_\_  
**\*Student Signature**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**