Student Health Form
Howard Community College
Health Science Division

Please complete all sections of this form and return to
Health Sciences Division Office HS 236

Name: __________________________

HCC ID#: ________________________

HEALTH FORM DEADLINES

Completed Health Form must be submitted prior to the following dates.
Late submissions may result in forfeiture of seat.
(If deadline falls on a holiday/weekend, paperwork is due the following business day.)

<table>
<thead>
<tr>
<th>Program</th>
<th>Due Date</th>
<th>Program</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td></td>
<td>Radiologic Technology</td>
<td>May 1</td>
</tr>
<tr>
<td>Summer Admission (Accelerated)</td>
<td>April 10</td>
<td>Physical Therapist Assistant</td>
<td>November 1</td>
</tr>
<tr>
<td>Fall Admission</td>
<td>July 10</td>
<td>Cardiovascular Technology</td>
<td>February 1</td>
</tr>
<tr>
<td>Spring Admission</td>
<td>December 10</td>
<td>Medical Laboratory Technician</td>
<td>December 10</td>
</tr>
<tr>
<td>LPN–RN Pathway (N103) Spring admit-February 1</td>
<td></td>
<td>Diagnostic Medical Sonography</td>
<td>December 10</td>
</tr>
<tr>
<td>LPN–RN Pathway (N103) Summer admit-June 1</td>
<td></td>
<td>Dental Hygiene</td>
<td>July 10</td>
</tr>
<tr>
<td>LPN–RN Pathway (N103) Fall admit-September 1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Program | Due Date
---|---
EMS-Paramedic - Fall | August 10
EMS-Paramedic - Spring | January 10

Criminal Background/Urine Drug Screen

<table>
<thead>
<tr>
<th>Admission Date</th>
<th>Complete Between:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summer</td>
<td>March 3 - April 10</td>
</tr>
<tr>
<td>Fall</td>
<td>June 5 - July 10</td>
</tr>
<tr>
<td>Spring</td>
<td>November 6 - December 10</td>
</tr>
</tbody>
</table>

Questions – Health Sciences Division Clinical Liaisons

HOTLINE: 443-518-1561
EMAIL: hsdcc@howardcc.edu
Offices: HS 353 & HS 354
You may scan/email or FAX your Health Information.

You must also submit a copy of current CPR and Criminal Background & Urine Drug Screen Email Order Confirmation with Health Form.

Make a copy of your paperwork PRIOR to submission.
You will not have access to the forms once they have been turned in.
SECTION I:

Name: ____________________________ ____________________________ ____________________________
Last     First     Middle Initial

Address: __________________________________________________________
Street

City     State     Zip Code

Phone: __________________________________________________________
Home       Cell

HCC ID#: ____________________________ Date of Birth: ____________________________

Preferred E-Mail: (Required) __________________________________________

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 allow faculty and EMS to contact this person in the event of illness or emergency to the HCC
student.

IMPORTANT

• Sections on pages 4, 5 and 7 MUST be completed by a licensed health care provider.

• Incomplete submissions may not be processed.

• Late health forms may result in Forfeiture of Seat.

• The Physician, Physician Assistant or Nurse Practitioner’s signature is required on this form

• Student signatures are required under Hepatitis Vaccination/Waiver, Health Sciences Policies and Student
Release of Information on pages 4, 6, and 9.

• A photocopy of your CPR card (front and back) must be submitted along with this paperwork. Only
American Heart Association BLS Provider will be accepted.

• Students should be aware that some facilities may not accept the moral waiver for the Seasonal Flu vaccine
which may lead to failure of the course.
To whom it may concern:

Please be aware that, according to CDC guidelines, healthcare providers and students of Health Sciences programs must have proof of immunity from titers. *History of disease and vaccination history are not acceptable for our program.*

Please order the following:

- **Titers:**  
  - IgG EIA Measles Antibody  
  - IgG EIA Mumps Antibody  
  - IgG EIA Rubella Antibody  
  - IgG EIA Varicella Antibody  
  - Hepatitis B Surface Antibody Quantitative Serum Titer

- If the student has either an *equivocal* or *negative* serologic test result, proof of a booster is required. *IgM tests are not required.*

- The student must have a documented initial Two-Step PPD skin test. (Second PPD is to be done 1-3 weeks after first PPD reading has been done.)

- A single PPD is required every year thereafter.

- Students with a history of a positive PPD or BCG vaccine should submit a copy of the Chest X-Ray Report as well as a Tuberculosis Questionnaire (included see page 5). The Tuberculosis Questionnaire is required every year thereafter.

- Proof of a current Tetanus within 8 years (preferably Tdap -the CDC recommends Tdap for healthcare providers)

Thank you for your assistance in this matter. Feel free to contact us with any questions.

Sincerely,

Health Sciences Division Clinical Liaisons  
Howard Community College  
443-518-1561
SECTION II:  ATTACH All Current Titer, and Booster Lab results to the last page of Health Form, or this form will not be accepted.  (SUBMIT ACTUAL LAB VALUES.)

Immunity Status (To Be Completed by Licensed Health Care Provider)

Measles, Mumps, and Rubella (MMR):

Titre Date: ______________________

If MMR Titre result was negative or equivocal, the booster is **required**.

*PLEASE ATTACH BOOSTER DOCUMENTATION

Booster Date: ______________________

Varicella:

Titre Date: ______________________

If Varicella Titre result was negative or equivocal, then booster is **required**.

*PLEASE ATTACH BOOSTER DOCUMENTATION

Booster Date: ______________________

History of disease is **not** sufficient.

Tetanus:

Td Date: ______________________

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

TDAP Date: ______________________

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: ______________________

STUDENT REVIEW AND COMPLETE THIS SECTION:

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 (required)*

Date

M:Clinical Coordinators/STUDENT HEALTH FORM – Revised 7-19-2016
SECTION III. Tuberculosis

All students entering the HCC Health Sciences Division programs must have a documented initial Two-Step PPD skin test. Second PPD to be done 1-3 weeks after first PPD reading has been done. A single PPD is required annually thereafter. 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 a PPD or questionnaire annually.

Part I. PPD Skin Test – (Due annually)

Date of first PPD Skin Test: ______ Date Read: ______ Results: ______
Date of second PPD Skin Test: ______ Date Read: ______ Results: ______

Part II. If PPD Skin Test is Positive or history of BCG vaccine

Date of Chest X-Ray (only has to be done once): ______ Report (attach copy): ______

Part III. Tuberculosis Questionnaire – (Due annually)

A Licensed Health Care Provider must complete this form. This Questionnaire is to be utilized if the student has a positive PPD Skin Test or a history of BCG vaccine.

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

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 Sciences program.

Provider’s Name: ________________________________ Date: __________
Office Address: ____________________________________________
__________________________________________________________
Phone Number: ____________________________________________

Signature of Licensed Health Care Provider: ________________________________
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 the beginning of the 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 Sciences Division of small pox vaccine status. **Note:** This vaccine is not required for admission into any of the Health Sciences Division clinical rotations.

4. **Health Insurance:**
   Howard Community College does not provide or sponsor health insurance for 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 must adhere to Essential Functions guidelines. (Please refer to Clinical Student Booklet, Health Sciences Division, p. 9-10.)

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I have read and understand the policies listed above:

*Student Signature* ____________________________  *Print Name* ____________________________  *Date* ____________________________
Seasonal Flu Vaccination Verification Form

This form must be completed by a licensed health care provider.

Name: ____________________________________________  HCC ID #: ________________

Date Administered: ________________________________

Injection Site: ____________________________________

Name of Health Care Provider: _________________________

Signature of Health Care Provider: _______________________

Name of Administering Facility: _________________________

Phone Number of Administering Facility: _______________________

Note:

- Flu season is October-April annually.
- Flu documentation is required for Spring admit students and in August/September for Fall admit students.
- Flu documentation is Not required for Summer admit students.
Certificate of Compliance for Vaccinations and Immunity
Vaccination Declination/Waiver form

Clinical Students/staff/faculty in Health Sciences Division are required to provide documentation of vaccination and/or immunity to Measles, Mumps, Rubella (MMR), Varicella and Influenza (seasonal flu vaccine). Howard Community College (HCC) follows CDC guidelines for Health Care Workers (HCW). HCC also contracts with affiliate agencies to provide clinical access to students in a Health Sciences Division program of study. Faculty, staff and students attending affiliate agencies must adhere to the policies and procedures as specified in the contract between HCC and the agency.

If vaccination is medically contraindicated, the student/staff/faculty, and licensed health care provider must sign a statement to that effect. (See below)

If vaccination conflicts with the students'/staff/faculty moral or religious tenets, the student must sign this written waiver to that effect.

This certificate of compliance should only go to those persons who do not meet our published requirements.

Name: ________________________________

Date of Birth: ____________________________  HCC College ID #: ______________________

Program/ Semester / Year of enrollment (if applicable: ________________________________

I have been notified of the requirement that I must provide documentation of having received vaccinations against Measles, Mumps, Rubella (MMR), Varicella and Influenza (seasonal flu vaccine).

AND

I AM SIGNING A DECLINATION/WAIVER FOR INFLUENZA VACCINE ______

Further, I certify that: (Place a check in the applicable space below.)

_____ I am exempt from the requirement and have a written statement from a licensed physician, which indicates that the vaccine is medically contraindicated. (REQUIRED)

AND/OR

_____ The administration of the vaccine conflicts with my moral or religious tenets.

Please list religious affiliation ____________________________

(A LETTER FROM RELIGIOUS LEADER IS REQUIRED.)

Students please read: I understand that an exemption from vaccination requirements may inhibit my ability to attend required clinical activities at agencies affiliated with the Howard Community College Health Sciences Division programs. I understand that affiliated clinical agencies have the right to deny access to their institution because of vaccination exemption. Further, if available affiliated agencies deny my access because of vaccination exemption, I fully understand that I may not be able to meet program completion requirements, and any absences incurred because of vaccination exemption or immunity status will count against the maximum allowed in the course.

I understand that all original forms must be turned in with health form documentation. I also understand I must keep a copy of these documents to produce on request to a clinical agency as required.

Signature: _______________________________________ Date: ___________________________

If declining vaccination due to moral reasons you must review attached CDC guideline handout entitled “Take 3 Steps to Fight the Flu” and sign below that you have received and understand this information.

Signature: _______________________________________ Date: ___________________________
Health Sciences Programs
STUDENT RELEASE OF INFORMATION FORM

Enrollment and participation in the Health Sciences Programs at Howard Community College (HCC) require that students provide proof of general and specific health status, immunization records, CPR certification, criminal background check, social security number, driver's license/photo identification card, academic records, urine/blood tests for drug screening and any other information that may be required by the college or clinical facility policy or legal mandate to establish students’ fitness to care for live patients in a clinical setting.

The Health Sciences Division is required to share this information with clinical facility partners who provide the sites for the required clinical training portions of the courses. Pursuant to the Family Educational Rights and Privacy Act of 1974, 20 U.S.C. 1231g (“FERPA”), the college may not release information without the written consent of the student; subject to the exceptions specified under FERPA. You may obtain more information about Student Rights and Responsibilities (FERPA) from your course catalog, student handbook, or college website www.howardcc.edu/admissions/register/ferpa. The clinical facilities are required to maintain the confidentiality of these records and may only use them to determine that a student meets the standards of the institution and thus does not present a threat to their patients or staff.

Choosing to not provide permission for the release of this information will prohibit participation in HCC Health Sciences Programs as it will result in a ban from the clinical facilities where students are required to complete the clinical portion of training. Admission to and successful completion of the clinical training portions of Health Sciences courses are required for program enrollment and completion.

<table>
<thead>
<tr>
<th>NAME OF STUDENT (Last, First, Middle Initial):</th>
<th>HCC ID NUMBER:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I understand that some of my records are protected under the Family Educational Rights and Privacy Act of 1974 and cannot be released without my written consent. I hereby grant permission for release of all applicable records described above to clinical facilities and grant access to those records by agents of those clinical facilities as required for my participation and completion in the HCC Health Sciences Program in which I am or intend to be enrolled. I certify that this consent has been given freely and voluntarily. I may revoke this consent at any time by providing written notice of such revocation to HCC Health Sciences Division. I understand that revocation of this consent will result in ineligibility to enroll in and/or continue in any HCC Health Sciences Program. This authorization is in effect for the duration of my participation and enrollment in HCC Health Sciences Program courses unless revoked in writing, and photocopies of this release form may be accepted, when presented in person with appropriate identification.

Student Signature  Date