INCOMING HEALTH CAREER STUDENT HEALTH EXAMINATION
PLEASE PRINT ALL INFORMATION

Name:	**HACC ID:**	**Date:**
Hawkmail Address:	**Phone:**	**DOB:**

STUDENT INFECTIOUS DISEASE SUMMARY

In order to participate in any clinical experience/observation where there is potential for direct patient contact (hands-on- care to observing within a radius of 4 feet) it is necessary that the following information be provided and verified by your physician/nurse practitioner/physician's assistant. To meet the requirements of our affiliating clinical agencies, the following diseases, immunizations or titers ***MUST*** be documented.

TUBERCULOSIS STATUS (choose 1)

BLOOD TEST TB INTERFERON ASSAY
(must be valid for the program year)
Date:_____
Results:_____positive_____negative
If result is indeterminant, proceed with 2-Step PPD test.

OR

BLOOD TEST TB T-SPOT
(must be valid for the program year)
Date:_____
Results:_____positive_____negative
_____borderline _____indeterminant
If result is borderline or indeterminant, repeat assay.

OR

2-STEP MANTOUX SKIN TEST (PPD)
(must be valid for the program year)

Tests must be read within 48 to 72 hours after administration. Please allow a minimum of 4 weeks between any PPD and administration of any live vaccine. (Per CDC guidelines)

Date Administered: #1_____**Date Read:** #1 _____
Result: Negative_____Positive_____mm_____

The second test must be a minimum of 7 days and a maximum of 21 days from the read date of the first.
Date Administered: #2_____**Date Read:** #2 _____
Result: Negative_____Positive_____mm_____

OR

Those students with proof of previously documented 2-step and continuous yearly testing (attach evidence):
Annual PPD Date:_____
Result: Negative_____Positive_____mm_____

****POSITIVE RESULT FOR ANY OF THE TESTING METHODS ABOVE:** 2 View Chest X-ray (completed within 2 years of date of admission):
Chest X-ray Date:_____
Chest X-ray Result: Positive or Negative (Circle one)
If NEGATIVE Chest X-ray: Complete the TB Screening/Self Reporting Form yearly.
If POSITIVE Chest X-ray: Isoniazid Prophylaxis Rx
Start date:_____Estimated End Date:_____

RUBELLA (GERMAN MEASLES) STATUS

Vaccination (given with MMR) – **2 injections** live virus vaccine on or after first birthday
Date(s)/Type (2 injections):
1._____
2._____
Booster dose recommended for those vaccinated prior to 1980.

OR

Rubella IgG Antibody titer (only required if no proof of immunizations)
Date:_____Result: Positive_____Negative_____

Booster Doses of MMR
Dates: 1._____2._____

MEASLES

Vaccination (given with MMR) – **2 injections** live virus vaccine on or after first birthday
Date(s)/ Type (2 injections):
1._____
2._____
Booster dose recommended for those vaccinated prior to 1980.

OR

Rubeola IgG Antibody titer (only required if no proof of immunizations)
Date:_____Result: Positive_____Negative_____

Booster Doses of MMR
Dates: 1._____2._____

MUMPS

Vaccination (given with MMR) - **2 injections** live virus vaccine on or after first birthday
Date(s)/ Type (2 injections):
1. _____
2. _____

OR

Mumps IgG Antibody titer (only required if no proof of immunizations)
Date:_____Result: Positive_____Negative_____

Booster Doses of MMR
Dates: 1._____2._____

Name:_____ Date: _____

VARICELLA (CHICKEN POX) STATUS	TETANUS/DIPTHERIA/PERTUSSIS STATUS
2 Doses Varicella Vaccine given 1 month apart: **Dates: 1._____2._____** *** Proof/documentation of disease will not meet this criteria!** **OR** **Varicella IgG Antibody titer** (only required if no proof of immunizations) Date:_____Result: Positive_____Negative_____ **Booster Dose of Varicella** (required for negative or equivocal titer result) **Date: 1._____ 2._____**	**All students MUST show proof of 1 dose of Tdap** **Date: _____** **If last tetanus shot is >10 years old, student must have tetanus booster Date: _____**

INFLUENZA STATUS

All students are required to have the **annual influenza** vaccine if attending clinical between October and March.

Date Administered:_____LOT #_____Manufacturer_____

****If completion of physical form is prior to flu season, student will need to complete separate form/show verification.**

VISION EXAM (Snellen Eye Chart or similar exam)

Normal_____ Referred for Correction: _____*

*If referred for correction, will need to provide documentation of referral.

REVIEW OF ESSENTIAL QUALIFICATIONS

According to my history and physical evaluation, review of immunizations and lab tests and review of the Essential Qualifications for the Health Careers Program (which are attached to this document); the student meets the essential qualifications to participate fully in the student clinical experience. **Yes_____ No _____**

COMMENTS:

Does the student have any activity limitations? **Yes_____No _____**

COMMENTS:

Does this student have any medical problems with which the school should be concerned?

Yes_____No _____If yes, please identify:

Is the student subject to conditions that may precipitate a medical emergency, such as:

Epilepsy_____Diabetes_____Allergies_____Fainting_____Heart conditions _____

Other_____Please identify

Does the student possess sufficient emotional stability to accurately perceive situations and make unimpaired observations and judgments regarding patient care in the clinical experiences of the health care program?

Yes_____No_____

COMMENTS:

Is there need for follow-up treatment? **Yes_____No _____**

If yes, please specify:

Does the student require a device or substance (including medications) to enable him/her to carry out the abilities required by the program? **Yes_____No _____**

If yes, specify:

Name:_____ Date: _____

Previous Vaccinations (not required)

HEPATITIS B STATUS	Hepatitis A Vaccine
Students who have received the vaccine series will need proof of 3 Hepatitis B vaccines: Dates: 1._____2._____3._____ **OR** **Students who have not yet received the vaccine** will need to receive three doses of Hepatitis B vaccine and have a follow up titer 4-8 weeks after the third injection**:** **Vaccine Dates:** 1._____2._____3._____ **Titer Date**:_____Results: _____ Please provide a copy of titer results. Immune Status:_____Positive_____Negative* **OR** ***IF unable to detail dates received, a Hepatitis B surface antibody titer can be performed** Date:_____Results: _____ Please provide a copy of titer results. Immune Status:_____Positive_____Negative* ***IF TITER NEGATIVE**: Student will need documentation of 3 doses of Hepatitis B Vaccine. Dates: 1._____2._____3._____ Second dose should be minimum of 4 weeks after the first, third dose should be a minimum of 8 weeks after the second, and a minimum of 16 weeks after the first. **If students are unable to get the Hepatitis B vaccines for medical reasons, they must sign a Non-Immunity Form** (available on CastleBranch website or from Program Director) **and have medical documentation from their healthcare provider**. *****Some clinical sites require Hepatitis B vaccination, signing a non-immunity form instead of getting the vaccination may affect the student's ability to attend clinical courses at those institutions.**	Vaccination Dates: Dates: 1. _____2. _____
	Pneumococcal Vaccine
	Vaccination Dates: Dates: 1. _____2. _____
	Meningococcal Vaccine
	Vaccination Dates: Dates: 1. _____2. _____
	Haemophilus Influenzae type B (Hib)
	Vaccination Dates: Dates: 1. _____2._____3. _____
	HPV Vaccine
	Vaccination Dates: Dates: 1. _____2. _____

_____ _____

Signature of Physician/ Nurse Practitioner/ Physician Assistant Date

_____

Printed Name

Address: _____

_____Phone Number: _____

STUDENTS IN NEED OF ACCOMMODATIONS:
Students with disabilities who are in need of accommodations should contact the campus disability coordinator listed below. Coordinators for each campus are listed here: http://www.hacc.edu/Students/DisabilityServices/Contact-Disability- Services.cfm

EEOC POLICY 005:
It is the policy of Harrisburg Area Community College, in full accordance with the law, not to discriminate in employment, student admissions, and student services on the basis of race, color, religion, age, political affiliation or belief, gender, national origin, ancestry, disability, place of birth, General Education Development Certification (GED), marital status, sexual orientation, gender identity or expression, veteran status, genetic history/information, or any legally protected classification. HACC recognizes its responsibility to promote the principles of equal opportunity for employment, student admissions, and student services taking active steps to recruit minorities and women.

The Pennsylvania Human Relations Act ("PHRAct') prohibits discrimination against prospective and current students because of race, color, sex, religious creed, ancestry, national origin, handicap or disability, record of a handicap or disability, perceived handicap or disability, relationship or association with an individual with a handicap or disability, use of a guide or support animal, and/or handling or training of support or guide animals.

The Pennsylvania Fair Educational Opportunities Act ("PFEOAct") prohibits discrimination against prospective and current students because of race, religion, color, ancestry, national origin, sex, handicap or disability, record of a handicap or disability, perceived handicap or disability, and a relationship or association with an individual with a handicap or disability.

Information about these laws may be obtained by visiting the Pennsylvania Human Relations Commission website at http://www.phrc.pa.gov/Pages/default.aspx#.V2HOujFuNS0.