NAUGATUCK VALLEY COMMUNITY COLLEGE
Community and Economic Development
HEALTH FORM

THIS FORM MUST BE COMPLETED, SIGNED BY HEALTHCARE PROVIDER AND TURNED IN TO CLASSROOM INSTRUCTOR BEFORE STUDENT IS ALLOWED IN ANY CLINICAL AREA. STUDENT IS RESPONSIBLE FOR MAKING THEIR OWN COPIES PRIOR TO HANDING IN ALL FORMS. NO FORMS WILL BE RETURNED TO THE STUDENT ONCE SUBMITTED.

QUESTIONS: CONTACT SHARON LUTKUS AT 203-596-2197 OR E-MAIL SLUTKUS@NV.EDU

NAME (Please Print)

ADDRESS

DATE OF BIRTH: TELEPHONE #

EMERGENCY CONTACT NAME_________________________________________________ TELEPHONE# _______________________

TO THE EXAMINING PHYSICIAN/HEALTH CARE PROVIDER:

Date of Exam_________________________ Latex Allergy (circle) YES NO

On the basis of my health assessment: Student is clear to participate in clinical nursing/allied health courses with NO restrictions (circle) YES NO

If NO please explain the nature of the restrictions/limitations related to providing safe care. (Note: anyone with any restrictions may be ineligible to participate in lab/clinical settings)

__________________________________________________________________________

__________________________________________________________________________

IMMUNIZATION ASSESSMENT:


MEASLES, MUMPS, RUBELLA: MMR #1 Date: _____________ MMR #2 Date: _____________

If no MMR vaccines, then must report Rubella and Rubeola Titers

<table>
<thead>
<tr>
<th>Rubella (German measles) Titer</th>
<th>Date/Results</th>
<th>Rubeola (Measles) Titer</th>
<th>Date/Results</th>
</tr>
</thead>
</table>

VARICELLA (CHICKEN POX)

*If “NO” IS CHECKED, PROVIDE TITER

Yes | No* | *Titer Results / Vaccine | Date | Provider Initials

DIPHTHERIA, PERTUSSIS & TETANUS

Yes | No* | *Titer Results / Vaccine | Date | Provider Initials

FLU VACCINE

Nov. 1 – April 1

Attach proof if not initialed

TETANUS booster (within 10 years)

Yes | No* | *Titer Results / Vaccine | Date | Provider Initials

All adults who have completed a primary series of tetanus/diphtheria product should receive Td booster every 10 years. For adults younger than 65 years of age, a 1-time dose of Tdap is recommended to replace the next Td.
ANNUAL TST (Tuberculosis Skin Test) - A 2-Step TST is required for all students in Danbury Programs. Tests must be 14 days apart. 1-Step TST is required in Waterbury. The Quantiferon blood test is an acceptable alternative to TST or chest x-ray in either location. For Questions about 2-Step TST, Healthcare providers may contact CT Dept. of Public Health, TB Specialist, at 860-509-7721. MMR vaccine and TST or Quantiferon must be given on the same day or the TST/Quantiferon cannot be given for 4-6 weeks. Dates must be within one year of the start of class.

TST#1: Date Planted: _______ Date Read _______ Results: _______ Signature: ____________________________________________
TST#2: Date Planted: _______ Date Read _______ Results: _______ Signature: ____________________________________________
A student with a positive TST must provide proof of a chest x-ray or Quantiferon Date: _______

Student shows no evidence of TB symptoms (circle) Yes No

HEPATITIS B - Hepatitis B vaccination is optional. You should discuss the option with your physician and either begin vaccination or sign waiver below. (Employers may provide opportunity for vaccine upon hire.)

#1 ___________________ #2 ___________________ #3 ___________________
Date                  Date                  Date                  

Hepatitis B Surface Antibody Titer: _______ Immune? Yes No Date

I WAIVE Hepatitis B vaccination at this time Signature: ___________________________ Date: _______

Healthcare Provider – Print Name: ___________________________ DEA # _______

Healthcare Provider – Signature: ___________________________ Date: _______

Rev. 99191: INSTRUCTIONAL SUPPORT/NAHCE/CNA/CLASSROOMHANDOUTS