HEALTH ASSESSMENT FORM

for

Students participating in Clinical Activities

ALL HEALTH REQUIREMENTS MUST BE COMPLETED AND SUBMITTED BY:

All requirements are to be submitted through

Castle Branch

by

July 15, 2022

A confidential document tracking system

Specific instructions to be provided at the

Nursing Orientation on

May 31, 2022
To the Examining Physician/Health Care Provider (HCP) Based on my health assessment and physical exam:

1. Student **DENIES** latex allergy: ☐  Student **CONFIRMS** latex allergy: ☐

2. Based on the Physical Examination date below, the student is cleared to participate in clinical course **WITH NO RESTRICTIONS:** Yes ☐  * No ☐

* If no, please explain the nature of the restrictions/limitations related to the delivery of patient care.

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### Documentation of Evidence of Vaccine Administration

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Record of Immunizations</th>
<th>Titer Results</th>
<th>ATTACHMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3. MMR</strong> Measles (Rubeola), Mumps &amp; Rubella (German Measles)</td>
<td>Record of Immunizations on or after 1st birthday: Dose 1 <em><strong>/</strong></em>/___  Dose 2 <em><strong>/</strong></em>/___ (at least 28 days apart)</td>
<td>Titer Results with lab report attached:</td>
<td><strong>OR</strong> (*) Tdap dose: / / (&lt; 10 years)</td>
</tr>
<tr>
<td><strong>4. Hepatitis B Antibody</strong> (Quantitative Titer is required following vaccination series)</td>
<td>Vaccination with Heplisav-B (2 dose) OR Engerix-B or Recombivax HB (3 dose), followed by a titer Dose 1: <em><strong>/</strong></em>/___ Dose 2: <em><strong>/</strong></em>/___ (one month after dose 1) Dose 3: <em><strong>/</strong></em>/___ (5 months after dose 2)</td>
<td>Titer Results (at least 1-2 months after final dose). Attach required lab report:</td>
<td><strong>AND</strong></td>
</tr>
<tr>
<td><strong>5. Varicella</strong> (Chicken Pox)</td>
<td>Dose 1: <em><strong>/</strong></em>/___</td>
<td>Titer Results with lab report attached:</td>
<td><strong>OR</strong></td>
</tr>
<tr>
<td><strong>6. TETNUS/DIPHTHERIA/PERTUSSUS</strong> (Tdap)</td>
<td>Tdap dose: / / (&lt; 10 years)</td>
<td>Td Booster ☐  <strong>OR</strong> Tdap Booster ☐</td>
<td><strong>OR</strong></td>
</tr>
</tbody>
</table>

^Students determined to be non-responders need documentation from their HCP
Connecticut Community College Nursing Program (CT-CCNP) Health Assessment Form
Gateway Community College: Academic Year 2022-2023

7. Initial TB Skin Test (TST) must be a two-step test:
   Test #1 date given: __/__/____
   Date read: __/__/____ Result: ________

   OR

   *TB Blood Test (IGRA, i.e. Quantiferon):
   Date of blood draw __/__/____
   Result: □ Positive □ Negative

   If either test is positive, a Chest X-ray is required w/lab report:
   Date of X-Ray: __/__/____ Result:
   □ Normal □ Abnormal

8. Influenza (Flu) Vaccination: Required every fall ~Seasonal date window to be determined

9. COVID VACCINE
   Product Name/Manufacturer: _______________ Lot Number: ____________ EXP: __________ Date: ______________
   Product Name/Manufacturer: _______________ Lot Number: ____________ EXP: __________ Date: ______________
   Product Name/Manufacturer: _______________ Lot Number: ____________ EXP: __________ Date: ______________

   Healthcare Provider (Please Print) Credentials DEA Number

   Healthcare Provider (Signature) Date of Physical Exam Date of Form Completion

Address: ______________________________ Telephone ______________________________

Based upon CDC Healthcare Personnel Vaccination Recommendations at:
https://www.cdc.gov/vaccines/adults/rec-vac/hcw.html CONNECTICUT COMMUNITY COLLEGE NURSING PROGRAM (CT-CCNP)
Gateway Community College

Student Statement of Responsibility

I understand that I must submit a completed Health Assessment form prior to participation in any clinical experiences.

I am aware that if my health status should change in a way that would impact my ability to perform in the nursing program, I must notify the Director/Administrator of the program immediately. The need for additional clearance will be determined at that time.

_____________________________
Student Name (Please Print)

_____________________________                      _________
Student Signature                                                                 Date
### VACCINE INSTRUCTIONS

<table>
<thead>
<tr>
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<th>Instructions</th>
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<tr>
<td><strong>MMR</strong>&lt;br&gt;Measles&lt;br&gt;Mumps&lt;br&gt;Rubella</td>
<td>- Submit proof of vaccination series or a titer (either qualitative or quantitative) showing immunity &lt;br&gt;  <strong>Quantitative</strong> is a lab value represented by a number  &lt;br&gt;- Allow for time to get a booster if titer is low</td>
</tr>
<tr>
<td>Varicella</td>
<td>Titer showing immunity, evidence of disease, or vaccine series acceptable.</td>
</tr>
<tr>
<td>Tetanus, Diptheria, Pertussis</td>
<td>- Must be within the last ten years and updated as needed throughout the program.  &lt;br&gt;- If within 10 years, Tdap meets requirements  &lt;br&gt;- If Tdap was more than ten years ago, Td booster meets requirements</td>
</tr>
<tr>
<td><strong>Hepatitis B (HepB)</strong></td>
<td><strong>PLEASE inform your provider that you must have a QUANTITATIVE titer drawn</strong>&lt;br&gt;- If you have already been vaccinated, you must submit a QUANTITATIVE titer. If your titer is positive, you meet requirements.  &lt;br&gt;- If you have been vaccinated and your titer is equivocal or negative, you must go through the series of immunizations again and have a QUANTITATIVE titer drawn (follow timeline under “If you’ve never been vaccinated”). If your second titer is still negative after a second complete series, you are considered a “non-responder” but still eligible for the program. You must submit a documentation from your healthcare provider stating your non-responder status.  &lt;br&gt;- If you’ve never been vaccinated, you must get a series of HepB vaccinations followed by a QUANTITATIVE titer.  &lt;br&gt;- Most providers do a three-dose series: &lt;br&gt;  o First dose is given, second dose is one month later, third dose is five months after that (example: Third dose is six months after the first dose)  &lt;br&gt;  o Draw a QUANTITATIVE titer two months after the third dose  &lt;br&gt;- You are still eligible for the program if you are in the process of getting the HepB series, but you must stay on track with the vaccinations and upload documentation to CastleBranch as you receive each dose.</td>
</tr>
<tr>
<td>PPD</td>
<td>- Must be done each year: blood test or skin test.  &lt;br&gt;- If you choose the skin test, a two-step PPD is required for your first year of school.  &lt;br&gt;  <strong>You must have two separate skin tests done 2-3 weeks apart.</strong>  &lt;br&gt;- Each test requires you to be planted, then read 48-72 hours later (total of four trips to health care provider required).  &lt;br&gt;- In following years, your renewal may be either blood test or single-step TB skin test  &lt;br&gt;- If history of positive TB test, you must submit a chest Xray (CXR) from the past year and submit radiology report. Each year after this, have your MD complete the TB screening form on CastleBranch. You do not need another CXR or TB test.</td>
</tr>
<tr>
<td>Influenza</td>
<td>- Due October 1 each year  &lt;br&gt;- Documentation must include all three of the following: The <strong>Manufacturer</strong> (NOT the vaccine name. This is a common error so be sure to clarify), the <strong>lot number</strong> and <strong>expiration date</strong> of the vaccine.  &lt;br&gt;- You must submit all of the above AND proof that you were vaccinated. If you receive your flu shot at a pharmacy, note: a pharmacy prescription alone is not evidence that were vaccinated, so be sure to provide the paperwork that it was ADMINISTERED along with the three required elements.</td>
</tr>
<tr>
<td><strong>COVID Vaccine</strong></td>
<td>- You must be fully vaccinated prior to starting the nursing program. This is a requirement by the clinical sites.  &lt;br&gt;- Fully vaccinated is defined as having the entire initial series plus the booster dose of the vaccine.</td>
</tr>
<tr>
<td>CPR/BLS</td>
<td>- Must be a course for healthcare providers. American Heart Association (BLS) and Red Cross (BLS for healthcare providers) offer the required course  &lt;br&gt;- Course must have a practical(hands-on) component <em>(No online ONLY courses)</em></td>
</tr>
</tbody>
</table>