This HEALTH REQUIREMENTS CHECK LIST is used to inform students entering Respiratory Care Program: RC 131, RC232, RC233, and RC234 of the required health documents.

- **Why do nursing, allied health students need this health form in addition to the college health form?** This Health form is needed to comply with the clinical site requirements which are different then the college health form requirements.

- **Respiratory students note:** these documents need to be turned in to Debra Waterman in Payne Hall 351.

- **The MVCC Health Information Form** (required for new students only) is a separate form submitted to the COLLEGE HEALTH CENTER located in Alumni College Center ACC104. All students must meet the College Health Center requirements in addition to the respiratory requirements; see the link on the mvcc.edu web site to obtain the college health form.

All documentation on the **checklist below** must be checked off as you will be required to have ALL the required documents and the *COPIES when you submit them to Payne hall 351.

- € **Take this Health Services Department Health Physical Form to your Health Care Provider to be completely filled out.** Do this in the summer (a complete physical/health assessment is required every year) after July 15th and before August 15th. Please submit to Debra Waterman before August 15th.

- € **Tuberculin Skin Test (TST- also referred to as Mantoux or PPD) results documented by Healthcare provider and or submit a *COPY of the report** which shows a **negative** reading. A Tuberculin test is required every year. **If the Mantoux states positive**, a chest x-ray is required to rule out tuberculosis. A copy of the chest x-ray report needs to be submitted to Ph 351. If you have a positive PPD you need to have an annual screening for TB and bring in a statement of evaluation or a copy of an evaluation form.

- € **Your healthcare provider will provide a script for a blood test at a lab for the titers below. A copy of your titer results must be submitted Debra Waterman, Payne Hall 351.**
  *The following **positive titers are required**:*
  - ✓ □ ***Rubella***
  - ✓ □ ***Rubeola***
  - ✓ □ ***Mumps***
  - ✓ □ ***Varicella***

  *If results are **negative or equivocal** appropriate additional booster shots must be administered.

- € **Note: Student must have Tetanus toxoid** immunization within 10 years
- € **Note: Student must have proof of Seasonal flu vaccine when available**
- € **Hepatitis B immunization sequence:** may be documented by the Healthcare provider or **a *COPY** of titer, If you do not have them you may sign the waiver on page 2 of the MVCC Health Form.
- € **Student must attend American Heart Association CPR for the Healthcare Provider** and submit a ***COPY of the card with this form**. It must be American Heart Association Healthcare Provider CPR the course is valid for 2 years and cannot expire before all your respiratory courses are complete.

Respiratory students please bring this entire packet with you when submitting to the college.

Mohawk Valley Community College **Required Nursing & Allied Health Department Health Form**

Name _____ M#_____Program _____

Address_____City_____State/ZIP_____

Date of Birth_____ M___ F___

Home Phone #_____ Cell Phone#_____

The following is to be completed by the Health Care Provider:

1. ***Tuberculin Skin Test*** *(TST)-Mantoux/PPD) is required*

   Date_____ Result_____ **(must be repeated every year)**

   If positive: Date of conversion _____ Reaction: _____ mm

   Date of CXR _____ Result_____

   Annual sign/symptom screening: date_____results_____

   Was treatment taken for a positive TST Yes ____ No _____

   Drug: _____ Date started _____ Date Completed _____

2. ***The following titers are required*** *(A positive titer is required; can not just provide proof of immunization)* ***a copy of lab report is required- one time****If results are **negative** appropriate booster shots must be administered.

Rubella Results _____ Date of booster vaccine: _____
Rubeola Results _____ Date of booster vaccine: _____
Mumps Results _____ Date of booster vaccine: _____
Varicella Results _____ Date of booster vaccine: _____

3. *Hepatitis B* (Requirement: 3 doses of vaccine or positive Hepatitis surface antigen antibody or signed waiver)

   Immunization: Dose #1_____ Dose #2_____ Dose #3_____

   Titer Date_____ Result_____ or Declination

   Waiver: I have read, or have had explained to me the information regarding Hepatitis B disease (see attached). I understand the risks of not receiving the vaccine. I have decided that I will not obtain immunization.

   Signature_____ Date_____

4. *Tetanus toxoid* within 10 years / date_____

5. *Seasonal flu* vaccine/ date _____

This student has had a complete physical, **can complete the Essential Functions**, and is in satisfactory physical condition to care for infant, child, and adult patients in an actual hospital/clinical setting.

Health Care Provider's Name:_____

Health Care Provider's Signature:_____

Date:_____ Address_____ Phone (___)_____

Please note: A complete physical is required the first year and an assessment the second year. Revised DKW 11.7.11