Naugatuck Valley Community College

# HEALTH FORM

## Waterbury

**This Health Form is required and due prior to lab/clinical experiences for the following programs.**

## CERTIFIED NURSE AIDE PROGRAM

**STUDENTS: Fill in areas under Please Print and Emergency Contact.**
**PROVIDERS: Fill in Physical exam and initial.**
**Scan e-mail all health forms to Cheryl Conaty, RN, C.N.A. Coordinator - cconaty@txcc.commnet.edu**

PLEASE PRINT

Name_____ Date of Birth_____ Banner ID# _____

Phone_____ Email _____

## EMERGENCY CONTACT

Name _____ Relationship to student _____ Phone# _____

Date of Physical Exam _____

Does student have a Latex Allergy? (circle) YES NO

Is student clear to participate in lab/clinical portion of Healthcare programs without restrictions? (circle) YES NO
If no, explain the nature of restrictions/limitations.

_____

_____

_____

_____

Would these limitations affect the student's ability to provide safe care? Please explain.

_____

_____

_____

Provider initial _____

**(OVER)**

Name_____ Date of Birth _____ Banner ID# _____

**If immunizations/vaccinations or blood titers are not obtained by this healthcare provider, please attach a document of proof. PROVIDERS: Please initial and circle in applicable areas for titers. Full dates required, not just the year.**

If titers are provided, they must be positive or show dates of vaccination(s).

**Measles, Mumps, Rubella** #1_____ #2_____ or Titer Immune (circle) YES NO Provider Initials _____
Immunization Dates

**Varicella (Chickenpox)** #1 _____ #2_____ or Titer Immune (circle) YES NO Provider Initials _____
Immunization Dates

**Td (TETANUS booster**)_____ Provider Initials _____
Date within 10 years

**Flu Vaccine** – **REQUIRED** _____ Provider Initials _____
Date given (must be given within the last year)

**Tuberculin Test/PPD** _____ _____ _____ **OR QFT-G**_____ _____ Provider Initials _____
Date given Date read Results Date done Results

**Hepatitis B series**_____ _____ _____ Provider Initials _____
Date/#1 Date/#2 Date/#3

***Titer not required if series completed.**

Hepatitis B Surface Antibody Titer_____ Immune (circle) YES NO Provider Initials _____
D

***COVID vaccine record include booster – Please attach – Please provide dates of vaccinations.**

**Date/#1 _____ Date/#2_____ (if not J&J) Date/Booster _____** Provider Initials _____

**I waive the Hepatitis B vaccination at this time.**

Student Signature: _____ Date: _____

**Note: The student must sign this waiver if they have not received all 3 vaccinations in the series OR NO IMMUNITY.**

## HEALTHCARE PROVIDER INFORMATION

Name_____ Telephone_____
Please print

Signature_____ Date _____

Address _____
No. and Street City or Town State Zip Code