Naugatuck Valley Community College

HEALTH FORM

Danbury Campus

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

Danbury Campus

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 Sasha Barata, RN, C.N.A. Coordinator – sbarata@nvcc.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 _____

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)

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

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

***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.

Name_____ Date of Birth _____ Banner ID# _____

Two-Step Tuberculosis Skin Test Record

This form is to be utilized to record the required initials two-stop tuberculosis skin testing with is part of the program health form. Please note 1-to-3-week intervals are recommended in-between each test.

Step 1 TB Test:

Lot # _____ Injection Site: _____

Date Administered: _____ Time Administered: _____

Health Care Provider Signature: _____

48-72 Hour Date Read: _____ Time Read: _____ Result: _____(mm)

Health Care Provider Signature: _____

Name_____ Date of Birth _____ Banner ID# _____

Step 2 TB Test:

Lot # _____ Injection Site: _____

Date Administered: _____ Time Administered: _____

Health Care Provider Signature: _____

48-72 Hour Date Read: _____ Time Read: _____ Result: _____(mm)

Health Care Provider Signature: _____

HEALTHCARE PROVIDER INFORMATION

Name_____ Telephone_____

Please print

Signature_____ Date _____

Address _____

No. and Street City or Town State Zip Code

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