NAUGATUCK VALLEY COMMUNITY COLLEGE
Community and Economic Development
H E A L T H F O R M

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 PATRICIA A. TARGETT, MA, RN AT 203-575-8253 OR E-MAIL PTARGETT@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:

Titers must be POSITIVE per laboratory standard. (Please refer to CDC Healthcare Personnel Vaccination Recommendations at http://www.immunize.org/catg.d/p2017.pdf .)

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

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

_____	_____	_____	_____
Rubella (German Measles) Titer	Date/Results	Rubeola (Measles) Titer	Date/Results

	Yes	No*	*Titer Results / Vaccine	Date	Provider Initials
VARICELLA (CHICKEN POX) *IF "NO" IS CHECKED, PROVIDE TITER	☐	☐	_____	_____	_____
DIPHTHERIA, PERTUSSIS & TETANUS	☐	☐	_____	_____	_____
FLU VACCINE Nov. 1 – April 1 Attach proof if not initialed	☐	☐	_____	_____	_____
TETANUS booster (within 10 years)	☐	☐	_____	_____	_____

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 xray 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_____