I give consent for PPSC Nursing Assistant Program (NUA) to share the results of the immunizations and physical questionnaire with clinical agencies as requested

____ ______________

Student Signature Date

Pikes Peak State College Nursing Program Health and Immunization Record

Student Name ____

Last First Middle Phone Number

Permanent Address ____

Street Number/Name City State Zip Code

Date of Birth [ ] [ ] [ ] (Mo Day Yr) PPCC S#________________________Student Email: ______________________________

Part A: TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. Enter all information in English.

REQUIRED FOR ALL STUDENTS

I. TETANUS, DIPHTHERIA & PERTUSSIS (Tdap)-booster must be within the last ten years [ ] [ ] [ ] (Mo Day Yr)

II. MMR (Measles, Mumps, Rubella)

Two doses required, at least one month apart… Dose #1 [ ] [ ] [ ] (Mo Day Yr) Dose #2 [ ] [ ] [ ] (Mo Day Yr)

Students in postsecondary education institutions, international travelers, and household or close personal contact of immunocompromised persons with no evidence of immunity to measles, mumps or rubella: 1 dose MMR if previously received 1 dose MMR, or 2-dose series MMR at least 4 weeks apart if previously did not receive any MMR. **-CDC, 2019**

OR ALL 3 OF THE FOLLOWING CRITERIA ARE MET:

MEASLES (RUBEOLA)

Has report of positive immune **titer**. **Specify date**: [ ] [ ] [ ] (Mo Day Yr) Value of Titer: ____________________

Or **two doses** of individual rubeola vaccine: Dose #1 [ ] [ ] [ ] (Mo Day Yr) Dose #2 [ ] [ ] [ ] (Mo Day Yr)

RUBELLA (GERMAN MEASLES)

Has report of positive immune **titer**. **Specify date**: [ ] [ ] [ ] Value of Titer: ____________________

Or **two doses** of individual rubella vaccine: Dose #1 [ ] [ ] [ ] (Mo Day Yr) Dose #2 [ ] [ ] [ ] (Mo Day Yr)

MUMPS

Has report of positive immune **titer**. **Specify date:** [ ] [ ] [ ] Value of Titer: ____________________

Or **two doses** of individual mumps vaccine: Dose #1 [ ] [ ] [ ] (Mo Day Yr) Dose #2 [ ] [ ] [ ] (Mo Day Yr)

Healthcare personnel born in 1957 or later with no evidence of immunity to measles, mumps or rubella: 2-dose series MMR at least 4 weeks apart for measles or mumps, or at least 1 dose MMR for rubella; if born before 1957, consider 2-dose series MMR at least 4 weeks apart for measles or mumps, or 1 dose MMR for rubella

CONTINUE on to Part B for Hepatitis B, Varicella, Tuberculosis Screening (Required for all students)

I give consent for PPSC Nursing Assistant Program (NUA) to share the results of the immunizations and physical questionnaire with clinical agencies as requested

_________________________________ _________________________________ ____________

Student Name (Print legibly) Student Signature Date

PART B: Hepatitis B, Varicella, Tuberculosis Screening

III. <u>HEPATITIS B</u>:

Has report of positive immune **<u>titer</u>**. **Specify date:** [ ] [ ] [ ] Mo Day Yr Value of Titer: ________________

Or **<u>three doses</u>** of individual hepatitis vaccine:

Dose #1 [ ] [ ] [ ] Mo Day Yr Dose # 2 [ ] [ ] [ ] Mo Day Yr Dose #3 [ ] [ ] [ ] Mo Day Yr

IV. <u>VARICELLA</u>: (chicken pox): Two doses one month apart recommended for adults with no history of disease:

Has report of positive immune **<u>titer</u>**. **Specify date**: [ ] [ ] [ ] Mo Day Yr Value of Titer: __________________
(*History of disease cannot be accepted*)

Or **two doses** of individual varicella vaccine: Dose #1 [ ] [ ] [ ] Mo Day Yr Dose #2 [ ] [ ] [ ] Mo Day Yr

V. <u>TUBERCULOSIS</u>:

1. Does the student have <u>signs or symptoms of active TBdisease?</u> ☐ YES ☐ NO

If NO, proceed to 2.

If YES, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

PLEASE USE THE SPACE BELOW TO DOCUMENT TUBERCULIN SKIN TESTING AND/OR CHEST RADIOGRAPHY (Based on assessment criteria outlined above)

2. A. <u>Tuberculin Skin Test/PPD</u>:

Date given: [ ] [ ] [ ] Mo Day Yr Date read: [ ] [ ] [ ] Mo DayM Yr Results:_______________MM
(Record actual MM of indurations, transverse diameter; if no in duration, write "0")

Interpretation (based on MM of indurations as well as risk factors)

☐ Positive ☐ Negative

B. <u>Chest X-Ray</u>: (required if tuberculin skin test is positive or if PPD has not been placed but patient is at risk of disease; must have been performed. *Must be within 5 years.

Result: ☐ Normal ☐ Abnormal Date of chest x-ray: _______________

INH Initiated ☐ ☐ Date________________X_____________months

C. <u>Quantiferon</u>: Date of Test:_______________ ☐ Positive (≥ 0.35 IU/mL) ☐ Negative

History of positive PPD and/or negative Quantiferon results requires <u>annual TB screening</u> with a Healthcare Provider:

1. Have you been having a bad cough that last longer than 2 weeks? ☐ YES ☐ NO
2. Have you been having pain in the chest? ☐ YES ☐ NO
3. Have you been coughing up blood or sputum (phlegm from deep inside the lungs)? ☐ YES ☐ NO
4. Have you experienced weakness or fatigue? ☐ YES ☐ NO
5. Have you experienced chills, fevers, or sweating at night? ☐ YES ☐ NO
6. Have you experienced weight loss or a loss of appetite? ☐ YES ☐ NO

<u>CONTINUE</u> on to Part C for <u>Influenza Vaccine</u> (Required for all students)

I give consent for PPSC Nursing Assistant Program (NUA) to share the results of the immunizations and physical questionnaire with clinical agencies as requested

_______________________________________ _______________________________________ _______________

Student Name (Print legibly) Student Signature Date

PART C. Influenza – During Current Flu Season

VI. INFLUENZA:

Date of last dose: [ ] [ ] [ ] Mo Day Yr Lot #____________________ Location given: _________________________

VII. COVID:

Dose 1 Date: [ ] [ ] [ ] Mo Day Yr Manufacturer: ___________________________

Dose 2 Date: [ ] [ ] [ ] Mo Day Yr Manufacturer: ___________________________

Booster Date: [ ] [ ] [ ] Mo Day Yr Manufacturer: ___________________________

HEALTH CARE PROVIDER: (signature required as validation of correct information for immunizations and TB assessment)

Printed Name:_____________________________________

Signature:____

Date:____

Address: ____
Street Number/Name

____
City State Zip Code

Phone: ____

CONTINUE on to Part D for Physician Statement (Required for all students)

I give consent for PPSC Nursing Assistant Program (NUA) to share the results of the immunizations and physical questionnaire with clinical agencies as requested

____ Student Signature   _______________ Date

PART D. Physician Statement

PLEASE PRINT: complete this form entirely—leave no question unanswered. If a question does not apply to patient, please answer "N/A" on that line.

Student Name:____DOB: ________________________

THIS SECTION TO BE COMPLETED BY PHYSICIAN OR PRIMARY CARE PROVIDER:

Height: ___________ Weight: __________ Pulse: __________

Blood Pressure:______________ Resp: _____________

Vision (Snellen): / R/L Corrected: Glasses ☐ Contacts ☐

Hearing R:_________L: _

Check line if normal:		**Within Normal Limits**	**Abnormal**
_____	General Appearance	☐	☐
_____	Head & Scalp	☐	☐
_____	Face	☐	☐
____	Skin	☐	☐
____	E.E.N.T.	☐	☐
____	Neck	☐	☐
____	Heart	☐	☐
____	Lungs	☐	☐
____	Breasts	☐	☐
____	Abdomen	☐	☐
____	Back & Spine	☐	☐
____	Extremities	☐	☐
____	Lymphatics	☐	☐
____	Neurological	☐	☐
____	Genitourinary	☐	☐

***Is general health adequate to allow participation in a nursing education program and to perform essential duties including CPR, administration of IV medication, opening of obstructed airways, catheterization, safe patient transfer/lifting, and other motor skills? YES NO ____**

Physician Statement continued on next page (Required for all students)

I give consent for PPCC Nursing Program to share the results of the immunizations and physical questionnaire with clinical agencies as requested

____ Student Signature   _____________ Date

Student Name:_________________________________DOB: ________________

Physician Statement - Continued

Past illnesses: ____
____

Injuries: ____
____

Hospitalizations: ____
____

Personal Medical History: (Please circle all that apply)

ADHD	Headaches	High Blood Pressure	Parkinson's disease
Alcoholism	Crohn's Disease	Kidney Stones	Peripheral Vascular Disease
Allergies, Seasonal	COPD/Emphysema	Kidney Disease	Peptic Ulcer
Anemia	Dementia	High Cholesterol	Psoriasis
Anxiety	Depression	HIV	Pulmonary Embolism (PE)
Arrhythmia (irregular heart beat)	Diabetes: 1 or 2	Hepatitis	Rheumatoid Arthritis
Arthritis	Diverticulitis	Irritable Bowel Syndrome	Seizure Disorder
Asthma	DVT (Blood Clot)	Lupus	Sleep Apnea
Bladder Problems/Incontinence	GERD (Acid Reflux)	Liver Disease	Stroke
Bleeding Problems	Glaucoma	Macular Degeneration	Thyroid Disorder
Cancer: ______________	Heart Disease	Mental Disorder	Ulcerative Colitis
	Heart Attack (MI)	Neuropathy	
	Hiatal Hernia	Osteopenia/Osteoporosis	

Allergies to medications: ____
____

Allergies to other substances: ____
____

Medications student is presently taking: ____
____

Present or chronic medical problems : ____
____

Health Care Provider Signature:_______________________________Date: ______________