Southeastern
COMMUNITY COLLEGE
Nursing & Healthcare Training

2023
STUDENT HEALTH FORMS
For Nursing and Healthcare Training Students

Name: _____

Address: _____

Student ID: _____ Phone #: _____

It is very important that you read and follow all directions in this packet.

DO NOT SEPARATE THIS PACKET!

Incomplete packets will not be accepted.

Southeastern
COMMUNITY COLLEGE
Nursing & Healthcare Training

A – 1.1 – Immunization Guidelines

Name: _____ Student ID Number: _____

GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

The immunization requirements must be met; or according to NC law, you will be withdrawn from classes without credit.

Acceptable records of your immunizations may be obtained from any of the following sources: (Be certain that your name, date of birth, and ID Number appear on each sheet and that all forms are mailed together. The records must be in black ink and the dates of vaccine administration must include the month, day, and year. **KEEP A COPY FOR YOUR RECORDS.**

- High School Records – These may contain some, but not all of your immunization information. Contact Student Services for help if needed. **Your immunization records do not transfer automatically. You must request a copy.**
- Personal Shot Records – Must be verified by a doctor's stamp or signature or by a clinic or health department stamp.
- Local Health Department
- Military Records or WHO (World Health Organization Documents)
- Previous College or University – **Your immunization records do not transfer automatically. You must request a copy.**

Immunizations According to Age:

Adapted from the CDC Recommendations (2016)

Age *If You Are*	**Td/Tdap** *Tetanus, diphtheria, pertussis*	**MMR** *Measles, mumps, rubella*	**Chicken Pox** *Varicella*	**Hepatitis A**	**Hepatitis B**	**Flu**
19-21						
22-26						
27-49						
50-59						
60-64						
65+						
Additional Information	*You should get a Td booster every ten years. You also need one dose of Tdap. Pregnant women should get a Tdap vaccine during every pregnancy to protect the baby*	You should get these if you were not vaccinated during childhood *Adults born prior to 1957 are normally considered immune*				*Yearly*

1. DTP (Diphtheria, Tetanus, Pertussis), Td (Tetanus, Diphtheria): One Td booster within the last ten years. Adults with an unknown or incomplete history of an initial 3 dose vaccination series with Td containing vaccines should begin or complete the primary series including a Tdap

Southeastern
COMMUNITY COLLEGE
Nursing & Healthcare Training

2. Measles: One dose on or after 12 months of age; second at least 30 days later. Must repeat Rubeola (measles) vaccine if received even one day prior to 12 months of age. Two measles doses if entering college for the first time after July 1, 1994.
3. One dose on or after 12 months of age. Only laboratory proof of immunity to rubella or mumps disease is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.

Southeastern
COMMUNITY COLLEGE
Nursing & Healthcare Training

A – 1.2 – Immunization Record Checklist

Southeastern Community College Nursing and Healthcare Training

Required Immunization Checklist

Name: _____ Student ID Number: _____

A complete immunization record from a physician, Clinic, or Health Department must be attached to this form.

Immunization Record Checklist:			
Tuberculosis Screening: *Required Documentation of a 2-step TST or IGRA blood assay*			
TB Skin Test #1 Date Placed:	Date Read:	Reading: _____mm induration (even if 0)	
TB Skin Test #2 Date Placed:	Date Read:	Reading: _____mm induration (even if 0)	
IGRA blood assay	Date:	Results:	
History of positive Skin Test?	Date:	Reading: _____mm induration	
Chest X-ray	Date:	Results	
Treatment with INH or other TB Medication	No: _____ Yes: _____	Length of Treatment: _____	
Pertussis: One Tdap vaccination required			
Initial Series completed: Dates #1_____ #2_____ #3_____			
Tdap (Boostrix or Adacel)	Date:		
Varicella (Chicken Pox): Two Vaccines Required or Positive Quantitative IgG Titer			
Varicella Vaccine	#1	#2	
Varicella Titer (copy of IgG lab report require	Date:	Titer Result	
Measles, Mumps, Rubella: Two Vaccines Required or Positive Quantitative IgG Titers			
MMR Combination Vaccine	#1	#2	
Measles (Rubeola) Vaccine	#1	#2	
Mumps Vaccine	#1	#2	
Rubella Vaccine	#1	#2	
Measles Titer (copy of IgG lab report require	Date:	Titer Result:	
Mumps Titer (copy of IgG lab report required	Date:	Titer Result:	
Rubella Titer (copy of IgG lab report required	Date:	Titer Result:	
Hepatitis B: (if using titer option, copy of Hep B surface Antibody Titer lab report is required)			
Hepatitis B Vaccine	#1	#2	#3
Hepatitis B Surface Antibody Titer	Date:		Titer Results:
Hepatitis B Vaccine (2nd series if indicated)	#1	#2	#3
Hepatitis B Surface Antibody Titer (or Titer Declination)	Date:		Titer Results:
Influenza: Seasonal Vaccination Mandatory October (or when available)			
Influenza Vaccination (NOT nasal flu mist)	Year #1	Year #2	

Signature or Clinic Stamp REQUIRED:

_____ _____

Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

_____ _____

Southeastern
COMMUNITY COLLEGE
Nursing & Healthcare Training

Print Name of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

Office Address **City** **State** **Zip Code**

A – 1.4 – Hepatitis B / Varicella Form

HEPATITIS B

ONLY FILL OUT PART A or PART B**, NOT BOTH**

Please read the following documents prior to signing below:
Hepatitis B General Fact Sheet http://www.cdc.gov/hepatitis/HBV/PDFs/HepBGeneralFactSheet-BW.pdf and Hepatitis B Vaccine sheet http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-hep-b.pdf

Part A – Compliance

I, (printed name) _____, in compliance with OSHA guidelines, agree to receive the Hepatitis B vaccine series. I have read the *Hepatitis B General Fact Sheet and Hepatitis B Vaccine* sheet and understand that I am at risk of contracting Hepatitis B due to my job or clinical related activities. I have discussed these options with my nursing advisor or my family physician and have been given the opportunity to ask questions and understand the risk factors involved.

_____ _____
Student Signature/Date Witness Signature/Date

Part B – Waiver

I, (printed name) _____, in compliance with OSHA guideline, have read the *Hepatitis B General Fact Sheet and Hepatitis B Vaccine* sheet and understand that I am at risk of contracting Hepatitis B due to my job or clinical related activities. I have discussed these options with my nursing advisor or my family physician and have been given the opportunity to ask questions and understand the risk factors involved. I am refusing to receive the Hepatitis B vaccine series, and agree to release and hold Southeastern Community College harmless from any claims or actions that may arise should I contract Hepatitis A or B. I also realize that by signing this declination some clinical facilities may not allow me to attend clinical rotations thereby making it impossible for me to complete the clinical objectives necessary to successfully complete the course.

_____ _____
Student Signature/Date Witness Signature/Date

Varicella (Chickenpox) Vaccine Declination Form

I, (printed name) _____, understand that I am at risk for contracting chickenpox because of my exposure to high-risk patients in the clinical setting. I understand that if there is no known immunity, the varicella vaccine is highly recommended for any student enrolled in an allied health program. I have discussed these options with my nursing advisor or my family physician and have been given the opportunity to ask questions and understand the risk factors involved. I am refusing to receive the Varicella vaccine, and agree to release and hold Southeastern Community College harmless from any claims or actions that may arise should I contract chickenpox I also realize that by signing this declination

some clinical facilities may not allow me to attend clinical rotations thereby making it impossible for me to complete the clinical objectives necessary to successfully complete the course.

_____ _____

Student Signature/Date Witness Signature/Date

A – 1.3 – Physical Examination Form

Name: _____ **Student ID Number:** _____

PHYSICAL EXAMINATION

Height _____ Weight_____ TPR ___/___/___ BP ___/___

VISION		**HEARING**	
Corrected	Right 20/ _____ Left 20/ _____	(gross)	Right _____ Left _____
or			
Uncorrected	Right 20/ _____ Left 20/ _____	15 ft.	Right _____ Left _____
Color Vision	_____		

Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Musculoskeletal			
8. Metabolic/Endocrine			
9. Neuropsychiatric			
10. Skin			

Is student under treatment for any medical or emotional condition? Yes _____ No _____
Explain _____

Is student physically and emotionally healthy? Yes _____ No _____
Explain _____

Southeastern
COMMUNITY COLLEGE
Nursing & Healthcare Training

Based on my assessment of this student's physical and emotional health on this date, he/she appears able to participate in the activities required of a health professional in a clinical setting in order to provide safe care to the public.

YES _____ NO _____
if No, please explain

_____

_____

_____
Signature of Physician/Physician Assistant/Nurse Practitioner / Date

_____ _____
Print Name of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

_____ _____ _____ _____
Office Address **City** **State** **Zip Code**