Connecticut Community College Nursing Program (CT-CCNP) Health Assessment Form~
Academic Year 2020-2021

Faculty Name:_____Date of Birth___/___/_____

Address:_____Phone:_____

Emergency Contact
Name:_____Phone:_____

To the Examining Physician/Health Care Provider (HCP)
Based on my health assessment and physical exam:

1. Individual **DENIES** latex allergy: ☐ Individual **CONFIRMS** latex allergy: ☐

2. Based on the Physical Examination date below, this individual is cleared to participate in clinical course activities **WITH NO RESTRICTIONS**: **Yes** ☐ * No ☐

* If no, please explain the nature of the restrictions/limitations related to the delivery of patient care.

Documentation of **Evidence of Vaccine Administration** must be provided for all vaccines below:

3. **MMR** Measles (Rubeola), Mumps & Rubella (German Measles) Record of Immunizations on or after 1st birthday: Dose 1___/___/___ Dose 2___/___/___ (4 weeks after Dose 1)	**OR**	Titer Results **with lab report attached**: Positive☐ Negative☐
4. **Hepatitis B Antibody^** **(Quantitative Titer is required following vaccination series)** Vaccination with Heplisav-B (2 dose) OR Engerix-B or Recombivax HB (3 dose), followed by a titer Dose 1: ___/___/___ Dose 2: __/___/___ (one month after dose 1) Dose 3: ___/___/___ (5 months after dose 2)	**AND**	Titer Results (at least 1-2 months after final dose). **Attach required lab report:** Positive☐ Negative☐ **^Students determined to be non-responders need documentation from their HCP**
5. Varicella (Chicken Pox) Dose 1: ___/___/___ Dose 2: __/___/___ (at least 28 days apart)	**OR**	Titer Results **with lab report attached:** Positive ☐ Negative ☐
6. TETNUS/DIPHTHERIA/PERTUSSUS (Tdap) Tdap dose: ___/___/___ (< 10 years**)**	**OR**	Td Booster ☐ **OR** Tdap Booster ☐ Date Given **___/___/___** (**if Tdap was >10 years ago**)

~Based upon CDC *Healthcare Personnel Vaccination Recommendations at:*
http://www.immunize.org/catg.d/p2017.pdf

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7. Initial TB Skin Test (TST) must be a two-step test: **Test #1** date given: ___/__/___ Date read: __/__/____ Result: _____ **Test #2** date given: ___/___/___ Date Read: __/__/____ Result: _____	**OR**	**TB Blood Test** (IGRA, i.e. Quantiferon): Date of blood draw___/___/___ **Result**: ☐ Positive ☐Negative **If either test is positive, a Chest X-ray is required w/lab report:** Date of X-Ray: ___/___/___ Result: ☐ Normal ☐ Abnormal

8. Influenza (Flu) Vaccination: Required every fall. Seasonal date window to be determined

Healthcare Provider (Please Print) **Credentials** **DEA Number**

Healthcare Provider (Signature) **Date of Physical Exam** **Date of Form Completion**

Address: _____ **Telephone_____**

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