“Initial Participant”

Used only for one of the following programs, please check:

☐ Nursing (RN)  ☐ Nursing (PN)  ☐ Respiratory Therapy  ☐ Certified Nursing Assistant  ☐ Phlebotomy

All sections of this health form must be completed in order to be eligible to participate in both clinical and classroom activities.

Students to submit documents to program leads. Please keep copies for future use.
Student must be able to meet all technical standards as listed below.

Note: Specific examples of Technical Standards can be found on the back of this page.

<table>
<thead>
<tr>
<th>Critical Thinking:</th>
<th>☐ Sufficient critical thinking and cognitive abilities in classroom and clinical settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionalism:</td>
<td>☐ Interpersonal skills sufficient for professional interaction with a diverse population of individuals, families and groups</td>
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<tr>
<td>Communication:</td>
<td>☐ Communication sufficient for professional interactions</td>
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<tr>
<td>Mobility:</td>
<td>☐ Physical abilities sufficient for movement from room to room and in small spaces</td>
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<tr>
<td>Motor Skills:</td>
<td>☐ Gross and fine motor abilities which are sufficiently effective and safe for providing allied health care</td>
</tr>
<tr>
<td>Sensory:</td>
<td>☐ Auditory and visual ability sufficient for observing, monitoring and assessing health needs</td>
</tr>
<tr>
<td>Observation:</td>
<td>☐ Ability to sufficiently make observations in a health care environment, consistent with program competencies</td>
</tr>
<tr>
<td>Tactile Sense:</td>
<td>☐ Tactile ability sufficient for physical assessment</td>
</tr>
</tbody>
</table>

Is the individual free of contagious illness?  ☐ Yes  ☐ No
If No, please explain: ________________________________
_________________________________________________________________________________

☐ I do hereby give my consent for the individual to fully participate in the classroom and clinical activities including complete patient care.

Additional Comments: ________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

_________________________                                _____________________
Health Care Provider Signature                                                                         Date

_________________________________________________                                _____________________
Please affix sticker or stamp with Provider name and address            Phone number

Note: All costs associated with this exam are the responsibility of the individual.
<table>
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<th>Examples</th>
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</table>
TB Testing: For Tuberculosis testing, please refer to page 5, Student Tuberculosis (TB) Testing.

Vaccinations: The following vaccine or titer results/records must also be submitted to the appropriate program coordinator or uploaded into ACEMAPP (if used by the program). If using ACEMAPP, the student may need to upload the same vaccination log multiple times in order to meet the various health requirements.

- **Measles/Mumps/Rubella:** Students are required to have valid documentation of 2 MMR vaccines OR have titers (bloodwork) drawn to document immunity. Titer results demonstrating “non-immune” or “equivocal” will require a student to receive 2 doses of MMR vaccine*, 1 month apart.
- **Varicella (Chicken Pox):** Students are required to have valid documentation of 2 Varicella vaccines OR have titers (bloodwork) drawn to document immunity OR have documentation of the disease by their Health Care Provider. Titer results demonstrating “non-immune” or “equivocal” will require a student to receive 2 doses of Varicella vaccine*, 1 month apart.
  - No additional titers required after receiving the vaccines as described above.

- **Tetanus Diphtheria & Pertussis (Tdap):** Students must receive a Tdap vaccine. Td booster required every 10 years
- **Hepatitis B:**
  - **Scenario #1:**
    - Students having previously completed the 3 part Hepatitis B vaccination series must be tested via a titer (blood test) verifying they are positive for Hepatitis B surface antibody (anti-HBs), thus immune to the disease.
    - Those whose results are either “non-immune” or “equivocal” must repeat the Hep B 3-part vaccination series at 1, 2 and 6 months. Your health care provider may opt to only offer you a single booster shot of Hep B vaccine verses repeating the three shot series (which is at your physician’s discretion).
    - A repeat titer is then required 1-2 months post-vaccination series completion
    - Students whose titers continue to read “non-immune” or “equivocal” are considered, “non-responders”, should be considered susceptible to HBV, and should be counseled regarding precautions and treatment via their health care provider.
    - Students are responsible for tracking these results and vaccine due dates along with re-titer dates as needed
  - **Scenario #2:**
    - Students who have not previously completed the 3-part Hepatitis B vaccination series must first obtain the 3-part vaccination series initially at 1, 2 and 6 months
    - A titer (blood test) to verify they are positive for Hepatitis B surface antibody (anti-HBs), thus immune to the disease, is required 1-2 months following the vaccination series completion.
    - Students whose titer results are either “non-immune” or “equivocal” must repeat the Hep B 3-part vaccination series at 1, 2 and 6 months
    - An additional Hep B titer is required, again 1-2 months post immunization
    - Students whose titers continue to read “non-immune” or “equivocal” are considered, “non-responders”, should be considered susceptible to HBV, and should be counseled regarding precautions and treatment via their health care provider
  - **Scenario #3:**
    - Students who have not previously completed the 3-part Hepatitis B vaccination series can also opt to obtain two doses ONLY of Heplisav-B (1 month apart) instead of 3 doses of the normally administered Hep B vaccine.
    - A titer (blood test) to verify they are positive for Hepatitis B surface antibody (anti-HBs), thus immune to the disease, is required 1-2 months following the vaccination series completion.
• Students whose titer results are either “non-immune” or “equivocal” must receive a booster shot of Heplisav-B at 1 month
• An additional Hep B titer is required, again 1-2 months post immunization
• Students whose titers continue to read “non-immune” or “equivocal” are considered “non-responders”, should be considered susceptible to HBV, and should be counseled regarding precautions and treatment via their health care provider
• Please note: Use of this vaccine has a 97% conversion to immunity rate; higher than the efficacy of use with the three shot series.

Note: Students are responsible for tracking these results and vaccine due dates along with re-titer dates as needed

**Flu vaccination:** Flu vaccination is required during flu season, October through March. Students entering any program in fall semester will receive email notification of an October due date for this requirement. Students entering any program in winter semester will be required to have flu shot documentation upon entry into the program.

NOTE: Vaccination against COVID-19 is required in order to participate in clinical learning activities. Students requesting vaccination exemption due to medical reasons should contact the Dean of Health Sciences/Director of Nursing. Students requesting vaccination exemption for religious reasons will be required to contact the Director of Human Resources/Affirmative Action Officer, Linda Torbet, to discuss the exemption process and requirements (ltorbet@monroeccc.edu). Although the College will work with students requesting an exemption, it cannot guarantee clinical placement for students that are not fully vaccinated which may impact a student’s ability to progress in his/her coursework and/or complete the program.
**Student Tuberculosis (TB) Testing**

1. Two-Step TB skin test (TST). A single annual TB screening schedule can be maintained every year thereafter.
2. Approved TB screening blood test.
3. If a person has a previously documented positive TB screening test or a documented diagnosis of TB or Latent TB Infection (LTBI) in the past, see option 3 below.

Name: ____________________________________    Student ID: _________________________
(Please Print)

**OPTION 1: 2-Step TST**

FIRST STEP OF THE TWO-STEP TB SKIN TEST (TST):
Date Test Given (mm/dd/yyyy): ______________ Test Given by: _______________________________
Site: ☐ Left Forearm ☐ Right Forearm Manufacturer/Lot #: _______________________________
Date Test Read (mm/dd/yyyy): _______________ Test Read by: _______________________________
Interpretation: ☐ Negative ☐ Positive Measurement of Induration (in millimeters): mm

SECOND STEP OF TWO-STEP TB SKIN TEST (TST):
Date Test Given (mm/dd/yyyy): ______________ Test Given by: _______________________________
Site: ☐ Left Forearm ☐ Right Forearm Manufacturer/Lot #: _______________________________
Date Test Read (mm/dd/yyyy): _______________ Test Read by: _______________________________
Interpretation: ☐ Negative ☐ Positive Measurement of Induration (in millimeters): mm

– OR –

**OPTION 2: TB Screening Blood Test**

INTERFERON-GAMMA RELEASE ASSAY (IGRA) – Quantiferon or T-Spot:
Date Test Given (mm/dd/yyyy): ______________ Test Given by: _____________________________
Interpretation: ☐ Negative ☐ Positive

**In the event of a positive result: If a tuberculin skin test or the IGRA blood test is positive or a person exhibits signs and symptoms suspicious for tuberculosis, a medical evaluation is required.**

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**OPTION 3:**
If a person has a previously documented positive TB screening test or a documented diagnosis of TB or Latent TB Infection (LTBI) in the past, perform an annual risk assessment/symptom check with your healthcare provider instead of the TST or IGRA. Repeat Chest x-ray is only required if symptoms develop.

**CHEST X–RAY**
Documentation that the Chest X-Ray was performed to rule-out tuberculosis due to a positive TB skin test, IGRA blood test or due to the development of signs or symptoms of tuberculosis must be in the Chest X-Ray report or comments.

Date of Chest X-Ray (mm/dd/yyyy): ______________
Interpretation: ☐ Normal ☐ Abnormal

Healthcare Provider Signature: _________________________ DATE: __________________________
Symptom Review Statement: