STUDENT ENTRANCE HEALTH VERIFICATION

Name:____

Address:____

City:_________________________State:_____Zip Code____________

Telephone Number: ____

Birth Date:____

Student ID Number:____

Please check correct program:

_______Dental Assistant
_______Early Childhood Education
_______Health Unit Coordinator
_______LPN
_______Medical Assistant
_______Nursing Assistant
_______Nursing Associate Degree
_______Pharmacy Technician
_______Phlebotomy
________Radiography
________Surgical Technician
________EMT-Basic
________EMT-Intermediate
________EMT-Paramedic

1. **Did you have chicken pox?** NO____ YES____ Date of Disease __________ **<u>OR</u>** Date(s) of Vaccine #1______ #2______

2. **Diphtheria/Tetanus Date:** _______________________________ (**required** within 10 years of program entry)

3. **Proof of (2) MMR's or Rubella and Rubeola titers.**
#3 NOT REQUIRED FOR DENTAL ASSISTANT STUDENTS**
Measles, Mumps, and Rubella (MMR) vaccinations and TB skin tests are available from the Public Health Nurses Office, Manitowoc 920-683-4155; Sheboygan, 920-459-3030 for a small fee. Your family physician may also give vaccinations and TB skin tests. Please call ahead and schedule an appointment.

1)MMR_________________________ ____
Date | Authorized Signature & Title OR a copy of the records

2)MMR_________________________ ____
Date | Authorized Signature & Title OR a copy of the records

<u>OR</u>

Rubella titer______________ _______ ____
Date Results | Authorized Signature & Title OR a copy of the records

Rubeola titer______________ _______ ____
Date Results | Authorized Signature & Title OR a copy of the records

4. **MANTOUX TUBERCULIN SKIN TEST** (**Required for program acceptance**) TB Skin test must be within the last year.

DATE GIVEN:__________________ ____
Authorized Signature & Title OR a copy of the records

DATE READ:___________________ ____
Authorized Signature & Title OR a copy of the records

_______NEGATIVE _______POSITIVE _______MM INDURATION

Chest x-ray indicated only when Tuberculin Skin Test is POSITIVE or HISTORY of positive reaction.
Please attach CXR reports and/or treatment reports.

5. **HEPATITIS B VACCINATION**

__________NO, I am declining the vaccination. **I am required to sign the declination on the back of this form.**
__________YES, I have completed or I am currently receiving the vaccine (list below).

1st_______________ ____
Date | Authorized Signature & Title OR a copy of the records

2nd_______________ ____
Date | Authorized Signature & Title OR a copy of the records

3rd_______________ ____
Date | Authorized Signature & Title OR a copy of the records

The Hepatitis B vaccine is not a requirement, but is recommended to protect the student from potential risks. (OVER)

6. TO BE COMPLETED BY PHYSICIAN/MEDICAL EXAMINER
*****#6 NOT REQUIRED FOR NURSING ASSISTANT, EMT-BASIC, EMT-INTERMEDIATE, OR EMT-PARAMEDIC STUDENTS****

I have examined this applicant and found him/her to be in good physical condition, free from communicable disease and, if entering the Early Childhood Education Program, physically able to work with young children.

Physician Signature:____

Print Name of Physician:_______________________________________

Address:____

City:__________________State:____________Zip Code:____________

Telephone Number:____

Date of Exam:____

(Physical is required before program acceptance and must be within three years of beginning clinical)

I am a student at Lakeshore Technical College and age 18 or older. I authorize Lakeshore Technical College to disclose a copy of this form to the health care facilities where I will be receiving my clinical instruction for the program indicated above. I understand that the information and the disclosure of the information is a necessary component of my clinical instruction requirements. This consent is effective for three years from signature date.

7. Student Signature: (required)____ Date:________________________

____ Date: ________________________

Parent/Guardian Signature **(required if under age 18)**

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HEPATITIS B VACCINATION DECLINATION

Fill out this section only if you choose NOT to receive the Hepatitis B vaccination at this time.

Some clinical facilities are requiring the student to begin the Hepatitis B vaccination series before placement in the clinical areas. Lakeshore Technical College and faculty recommend that each student be immunized for Hepatitis B to protect the student from potential risks.

I have read the information about Hepatitis B and the Hepatitis B vaccine. I understand that I maybe at risk of acquiring Hepatitis B virus infection; however, **I choose to decline the Hepatitis B vaccination at this time.** I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. I will assume full liability as a result of declining the vaccine while on campus or while participating in program-related clinical assignments. Should an exposure occur during a classroom or clinical experience, neither the college nor the clinical facility can be held liable and/or responsible for cost incurred.

I authorize Lakeshore Technical College to disclose a copy of this form to the health care facilities where I will be receiving my clinical instruction. I understand that the information and the disclosure of the information is a necessary component of my clinical instruction requirements.

Students Signature (Required):______________________________________Date:________________________________

____Date:________________________________

Parent/Guardian Signature **(required if under age 18)**

Please Mail to:
LAKESHORE TECHNICAL COLLEGE
College Health Nurse
1290 North Ave
Cleveland WI 53015-1414