Health Form Instructions

1. Proof of chickenpox can be completed by turning in a blood test (titer) result or showing proof of 2 vaccines in your lifetime. Radiography students must have a titer. History of having the disease as a child is not proof.

2. You need to show proof of having a Tdap booster in the last 10 years.

3. You need to show proof of having 2 MMR (Measles, Mumps, Rubella) vaccinations in the past OR turning in 3 blood test (titer) results, one each for Measles, Mumps and Rubella. This is not required for Dental Assistant Students.

4. You need to show proof of having a two-step Tuberculin (TB) skin test, TB Gold blood test, or T-spot test in the last year. The College nurse is able to do the TB skin test on the Cleveland campus.
   If you have tested positive in the past, you need to submit a copy of the positive skin test, chest x-ray report, any treatment received, and complete a previous positive form (available from the college nurse).

5. You need to show proof of having completed the series of 3 Hepatitis B vaccines or sign the declination statement on the second page of the form.

6. You need to show proof of a current season flu shot. However, if you are applying in late spring and summer, flu shots are not available. In that case, you will need to get the shot as soon as it becomes available in fall.

7. You need to show proof of a physical within the last 3 years. This is only required for the Dental Assistant, Early Childhood Education, Ophthalmic Medical Assistant, & Pharmacy Technician.

8. You need to sign the health form.

Blood tests are obtained from any provider that can perform laboratory testing. Vaccines can be obtained from the local public health department, the occupational health departments at your local clinic or hospital, or your private physician.
Proof is submitted by a provider signature on the form or a copy of the record. Students are responsible for any costs for the above services.

If questions on these requirements, please contact:
Lakeshore Technical College
College Health Nurse
1290 North Ave
Cleveland WI 53015-1414
E-mail: Renee.bruckschen@gotoltc.edu
Fax: 920.693.3561
Phone: 920.693.1111

STUDENT ENTRANCE HEALTH VERIFICATION

Name:_____

Address:_____

City:_____State:____Zip Code_____

Telephone Number: _____

Birth Date:_____

Student ID Number:_____

Please check correct program:

_____Dental Assistant
_____Dietary Aide
_____Early Childhood Education
_____EKG/Phlebotomy
_____EMT - _____
_____Health Care Technician
_____Health Info. Management
_____Health Unit Coordinator
_____Medical Coding/Assistant
_____ NA/PN/RN
_____Ophthalmic M. Assistant
_____ Pharmacy Technician
_____ Radiography

1. **Proof of Chickenpox:** Varicella Titer Date & Results_____ **OR** Dates of Vaccine #1 _____#2_____(attach copy)

2. **Diphtheria/Tetanus Date:** _____(Tdap) (**required** within the last 10 years)

3. **Proof of (2) MMR's or Rubeola, Mumps, and Rubella titers.** (***NOT REQUIRED FOR DENTAL ASSISTANT STUDENTS)***

1)MMR_____ _____
Date Authorized Signature & Title OR a copy of the records

2)MMR_____ _____
Date Authorized Signature & Title OR a copy of the records

OR

Rubeola titer_____ _____ _____
Date Results Authorized Signature & Title OR a copy of the records

Mumps titer_____ _____ _____
Date Results Authorized Signature & Title OR a copy of the records

Rubella titer_____ _____ _____
Date Results Authorized Signature & Title OR a copy of the records

4. **2 Step Mantoux Tuberculin Skin Test** (**Required for program acceptance**) within the last year OR TB Gold test. (Attach copy)

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. **Proof of a current season flu shot is required**. A waiver for legitimate medical or religious exemptions is available but must be submitted and approved prior to the start of clinical. Submit a copy of this record.

7. TO BE COMPLETED BY PHYSICIAN/MEDICAL EXAMINER

****Only Required for Dental Assistant, Early Childhood Education, Ophthalmic Medical Assistant & Pharmacy Technician 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 the last three years)

8. I am a student at Lakeshore Technical College. 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.

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 <u>choose NOT to receive the Hepatitis B vaccination</u> 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 <u>at this time</u>.** 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.

Student Signature: (required)_____ Date:_____

_____ Date: _____

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

Please Mail, E-mail or Fax to:
LAKESHORE TECHNICAL COLLEGE
College Health Nurse
1290 North Ave
Cleveland WI 53015-1414
E-mail: Renee.bruckschen@gotoltc.edu
Fax: 920.693.3561
Phone: 920.693.1111