

## 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.
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





7. **TO BE COMPLETED BY PHYSICIAN/MEDICAL EXAMINER**

**\*\*Only Required for Dental Assistant, Early Childhood Education, & Ophthalmic Medical Assistant\*\***

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 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.

**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