

NAUGATUCK VALLEY COMMUNITY COLLEGE

Nursing and Allied Health, Continuing Education

HEALTH FORM

THIS FORM MUST BE COMPLETED AND SIGNED BY YOUR HEALTHCARE PROVIDER AND TURNED IN TO CLASSROOM INSTRUCTOR BEFORE STUDENT IS ALLOWED IN ANY CLINICAL AREA. QUESTIONS: CONTACT PATRICIA A. TARGETT, MA, RN @ 203-575-8253 OR E-MAIL PTARGETT@NVCC.COMMNET.EDU

NAME

ADDRESS

Date of Birth:

TELEPHONE #

On (Date) _____ (Name) _____ was examined and found to be in good health. He/she is free of any communicable disease and has no known deficits that would interfere with the ability to participate in the lab/clinical setting.

X HEALTHCARE PROVIDER SIGNATURE _____

ADDRESS

PHONE NUMBER

A PREGNANT STUDENT REQUIRES OB/GYN HEALTHCARE PROVIDER ASSESSMENT CALL 596-2108 FOR ADDITIONAL FORM COMMENTS: (ATTACH SEPARATE PAGE, IF NECESSARY)

IMMUNIZATIONS

CT STATE LAWS REQUIRE THAT STUDENT/INSTRUCTOR BORN ON OR AFTER JANUARY 1, 1957 BE PROTECTED AGAINST MEASLES AND RUBELLA. CLINICAL SITES ALSO REQUIRE THAT STUDENTS/FACULTY HAVE TUBERCULIN TESTING PRIOR TO BEGINNING CLINICAL EXPERIENCE. PLEASE COMPLETE YOUR IMMUNIZATION HISTORY.

MMR #1 date: _____

MMR #2 date: _____

If you have no MMR vaccine, then you must report your rubeola and rubella titers:

Rubeola Titer (date/results)

Rubella Titer (date/results)

HISTORY OF DISEASE (*IF "NO" IS CHECKED, TITER MUST BE DONE AND RESULTS DOCUMENTED)

Yes or No*

*Titer Results

Date

VARICELLA (CHICKEN POX)

D.P.T.

(DIPHTHERIA, PERTUSSIS & TETANUS*)

*Tetanus booster within 10 years

TUBERCULOSIS: ALL Danbury students need 2-Step (PPD #1 and #2 ~14 days apart); all others are only required to have 1-Step TB test (PPD #1 only) Questions about 2-Step PPD healthcare provider may contact the state dept of public health TB specialist at 860-509-7721.

PPD#1: Planted/Date: _____ Read/Results: _____ PPD #2* Planted/Date: _____ Read/Results: _____

Dates must be within the past six (6) months

If PPD is POSITIVE, results of chest x-ray (within past year), and note from healthcare provider regarding treatment plan must be attached.

(Results of X-Ray)

(Date)

HEPATITIS B - Hepatitis B vaccination is optional. You should discuss the option with your physician and either begin vaccination or sign waiver below. (Employers will provide opportunity for vaccine upon hire.)

#1 _____ date

#2 _____ date

#3 _____ date

I WAIVE Hepatitis B vaccination at this time: Student Signature / Date