

# HEALTH FORM

|                      |                       |
|----------------------|-----------------------|
| <i>Please circle</i> | CNA                   |
| <i>program</i>       | PCT                   |
|                      | Phlebotomy Technician |
|                      | Veterinary Assistant  |

**This form must be completed and signed by your Health Care Provider.  
 Return form to MxCC Continuing Education Office.**

Questions: Contact Diane Bordonaro MSN RN at (860)343-5716  
 or email dbordonaro@mxcc.edu

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Phone number \_\_\_\_\_

On (date) \_\_\_\_\_ I examined this student and found him/her to be in good health. He/she is free of any communicable disease, can lift 50 pounds and has no known deficits that would interfere with the ability to participate in a clinical setting.

Pregnant: Yes No (please circle)

**Healthcare Provider**

**STAMP**

**Signature:** \_\_\_\_\_

Phone number: \_\_\_\_\_

Comments: \_\_\_\_\_

**IMMUNIZATIONS - Required for all CNA, PCT and Phlebotomy Technician Students  
 Veterinary Assistant students do not need to submit immunization information**

|  | <u>DATE</u> | <u>RESULT</u> |
|--|-------------|---------------|
| <b>1 MMR</b> (one must be given after 1980)                                |             |               |
| MMR #1   | _____       |               |
| MMR #2   | _____       |               |
| <b>2 Rubella Screening</b>   |             |               |
| Rubella serum test for immunity  | _____       | _____         |
| Rubella immunization   | _____       | _____         |
| <b>3 Measles Screening</b>   |             |               |
| Measles serum test for immunity  | _____       | _____         |
| Measles immunization   | _____       | _____         |
| <b>4 Mumps Screening</b>   |             |               |
| Mumps serum test for immunity  | _____       | _____         |
| Mumps immunization   | _____       | _____         |
| <b>5 Varicella (Chicken Pox) History</b>                                   |             |               |
| Varicella Vaccine #1   | _____       |               |
| Varicella Vaccine #2   | _____       |               |
| Varicella antibody test  | _____       | _____         |
| History of disease   | _____       |               |
| <b>6 Tetanus vaccine</b> (must be given within last 10 years)              | _____       |               |
| <b>7 Hepatitis B Vaccine series</b>  | <u>#1</u>   | <u>#2</u>     |
| Hep B test for immunity  | _____       | _____         |
| <b>8 Seasonal Influenza Vaccine (Required Spring &amp; Fall semesters)</b> |             | _____         |

Student Name \_\_\_\_\_

**ANNUAL TUBERCULOSIS SCREENING**

**Students in the CNA program are required to have a One Step Tuberculosis Skin Test.**  
**Students in the PCT and Phlebotomy Technician programs must have a Two Step Skin Test.**

Tuberculosis screening must be done **within 12 months** of admission to the program.  
Previous BCG Vaccine does not exempt student from tuberculosis screening.  
A QuantiFERON blood test is an acceptable alternative to skin testing

|   | <b>Date</b> | <b>Results</b> | <b>Date/Signature</b> |
|---|-------------|----------------|-----------------------|
| TB Skin Test #1                               | _____       | _____          | _____                 |
| TB Skin Test #2<br>(Phlebotomy students only) | _____       | _____          | _____                 |
| <b>or</b>                                     |             |                |                       |
| TB Blood Test (QFT-G)                         | _____       | _____          |                       |
| Chest x-ray<br>(if above testing is positive) | _____       | _____          |                       |

**HEPATITS B WAIVER**

Hepatitis B vaccination is optional. You should discuss this option with your primary care provider and either begin the vaccination series or sign the waiver below.

I waive Hepatitis B vaccination at this time.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL INSURANCE**

Medical Insurance is required for all students.  
I certify that I carry a current Medical Insurance Policy

Student Signature \_\_\_\_\_ Date \_\_\_\_\_