All Health Career and Nursing students are required to attend internship/clinical/practicum experiences at external and/or internal facilities. These facilities have outlined specific immunization obligations mandated for entrance. These immunization obligations may vary from facility to facility; however, all immunization obligations are accounted for in the listing of required immunizations above. The inability of a student to obtain one or more of the required immunizations for personal, religious, and/or medical reasons may bar the student from beginning or completing their internship/clinical/practicum experience at one or more facilities. The inability of the program to place a student in a facility for internship/clinical/practicum experience, based upon a student’s inability to obtain one or more required immunizations, may cause a student to be denied entrance into the program or dismissed from the program. Students who are not able to obtain all required immunizations should contact their program manager as soon as possible.

If using this form for proof of immunity, each signature box must be signed next to any immunization information entered.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Date of immunization or Date and Result of Titer Drawn</th>
<th>Healthcare Provider Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tdap</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| • Documented single dose of Tdap, (must be Tdap – Dtap, DT, DTP not acceptable) or Positive antibody titer for all three diseases | Titer: Tetanus
   Date: __________
   Results: Positive / Negative/ Equivocal (circle one)                  | Sign:____________________                        |
| • Td is required every 10 years after the Tdap                             | Titer: Diphtheria
   Date: __________
   Results: Positive / Negative/ Equivocal (circle one)                  |                                |
|                                                                            | Titer: Pertussis
   Date: __________
   Results: Positive / Negative/ Equivocal (circle one)                  |                                |
|                                                                            | OR
|                                                                            | Date of vaccine: __________                        |                                |
| **MMR**                                                                    |                                                        |                                |
| - **Measles (Rubeola)**                                                    |                                                        |                                |
|   • Serologic evidence of immunity (positive titer) or if titer is negative, documentation of vaccination with two does of measles vaccine | Titer: Measles
   Date: __________
   Results: Positive / Negative/ Equivocal (circle one)                  | Sign:____________________                        |
|                                                                            | If negative titer
|                                                                            | Date of Vaccine:
|                                                                            | #1 __________
|                                                                            | #2 __________                        |
|                                                                            | Titer: Mumps
   Date: __________
   Results: Positive / Negative/ Equivocal (circle one)                  |                                |
|                                                                            | If negative titer
|                                                                            | Date of Vaccine:
|                                                                            | #1 __________                        |

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6.25.2015

c:/users/jsmith2/appdata/local/microsoft/windows/temporary internet files/content.outlook/527bb0d0/immunization form in revision 6 22 15.docx
### Rubella
- Serologic evidence of immunity (positive titer) **or** if titer is negative, documentation of vaccination of one dose of rubella vaccine

| #2__________ | Titer: Rubella  
| Date: ________ | Results: Positive / Negative/ Equivocal  
| (circle one) |  

**If negative titer**  
**OR**  
**Date of Vaccine:**  
#1__________  
Sign:____________________

### Hepatitis B
Written documentation of 3 doses of vaccine **and/or** proof of positive titer.

| Date of Vaccine: | #1__________  
| #2__________ |  
| #3__________ | AND/OR  
| Titer: | Date:  
| Results: Positive / Negative/ Equivocal  
| (circle one) |  

Sign:____________________

### Tuberculosis
- Documentation of a negative 2-step TST (Double Mantoux) within the last 12 months  
**or**  
Documentation of two negative 1-step TST within one year period (most recent within last 12 months)  
**or**  
Documentation of previous 2-step PLUS subsequent annual 1-step test  
**or**  
Documentation of a negative QuantiFERON Gold or T-Spot test within the past 12 months  
- **If TB results are positive** due to latent tuberculosis disease, provide a Chest X-Ray (lab report or employer health report required). Only one chest X-ray is required. If INH therapy was received, you must submit documentation of this as well. Students with a positive result due to latent TB are required to show proof that no signs of active TB are present through a medical provider verification statement **annually**.

- **Tuberculosis (Single PPD)** A single PPD is required **annually**

| Date Given_____________ | Date Read_____________ | Result______________  
| **STEP 1**  
| Date Given_____________ | Date Read_____________ | Result______________  
| **STEP 2**  
| Date Given_____________ | Date Read_____________ | Result______________  
| OR  
| IGRA blood test i.e.: QuantiFERON-TB  
| Date: _____________ | Result: _____________ |  
| OR  
| Last Two Annuals (or enter one annual date and result in addition to two-step if no two-step in the last 12 months)  
| Date: _____________ | Result: _____________ |  
| Date: _____________ | Result: _____________ |  

Sign:____________________

### Varicella -Chicken Pox, Herpes Zoster (Shingles)
- Serologic evidence of immunity (positive titer) **or** if titer is negative, documentation of two doses of varicella vaccine 4-8 weeks apart is required

| Date: _____________ | Titer:  
| Results: Positive / Negative/ Equivocal  
| (circle one) |  

**If negative titer**  
Sign:____________________
<table>
<thead>
<tr>
<th><strong>Influenza Vaccine</strong></th>
<th>Date of Vaccine:</th>
</tr>
</thead>
</table>
| Documentation of annual influenza vaccination. (Between August 1 and October 1). Timing is subject to change based on vaccine supply and clinical affiliate request. Please consult with your program manager. | #1        
#2        |

<table>
<thead>
<tr>
<th><strong>Date of Vaccine:</strong></th>
<th><strong>Sign:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>____________________</td>
<td>__________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Pre-Exposure Rabies Vaccine</strong></th>
<th>Date of Vaccine:</th>
</tr>
</thead>
</table>
| **Vet Tech ONLY**             | #1        
#2        
#3        |

<table>
<thead>
<tr>
<th><strong>Date of Vaccine:</strong></th>
<th><strong>Sign:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>____________________</td>
<td>__________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Vision Exam</strong></th>
<th>Date of Exam:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation and results of exam must be provided. (Optical Programs, MLT, Phlebotomy and Dental Hygiene ONLY)</td>
<td>__________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Date of Exam:</strong></th>
<th><strong>Sign:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>________________</td>
<td>__________</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Color Blindness Test</strong></th>
<th>Date of Exam:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(MLT and Phlebotomy ONLY)</td>
<td>__________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Date of Exam:</strong></th>
<th><strong>Sign:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>________________</td>
<td>__________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Dental Exam with Radiographic Images</strong></th>
<th>Date of Exam:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation and results of exam must be provided. (Dental Hygiene ONLY)</td>
<td>__________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Date of Exam:</strong></th>
<th><strong>Sign:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>________________</td>
<td>__________</td>
</tr>
</tbody>
</table>

**Provider Information:**
Facility Name (If applicable): ________________________________

Provider Name: ________________________________

Provider Credentials: ________________________________

Provider Address:

__________________________________________________________

__________________________________________________________

Provider Phone: ________________________________

(If more than one provider is used to verify immunizations – provider information for all providers signing off on immunizations requirements must be listed)
HEALTH RELEASE FORM

This is to certify that ________________________________ had a physical exam on ________________ and is in apparent good health, has no condition that would endanger the health and well-being of other students or patients, and is physically/mentally able to participate in the Health Career/Nursing Program at Cuyahoga Community College.

Provider’s Signature: __________________________

Printed Name: __________________________

Address: __________________________________________________________________________________

Office Phone Number: __________________________

Comments:

I certify by my signature that this information is true and that I can provide documentation, upon request.

Student’s Signature: __________________________

Printed Name: __________________________ Date: ______________
HEALTH INSURANCE ATTESTATION

Student Name: __________________________________________

Name of Insured: ______________________________________

Relationship to Insured: ________________________________

Insurance Provider: _________________________________

Policy Number: ______________________________________

Group Number: ______________________________________

I certify by my signature that this information is true. I ________________________________, attest that as required by law, I have a current health insurance plan which I will maintain through the entirety of the health career program. I understand that I am required to present proof of my health insurance plan to a clinical agency or Cuyahoga Community College immediately upon request.

Student’s Signature: __________________________________

Printed Name: ________________________________________ Date: ______________________