Cuyahoga Community College

Health Careers and Nursing
Immunization and Health Requirement
Completion Guide

HEALTH CAREERS AND NURSING IMMUNIZATION AND HEALTH REQUIREMENT COMPLETION GUIDE

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HEALTH CAREERS AND NURSING IMMUNIZATION AND HEALTH REQUIREMENT COMPLETION GUIDE

OVERVIEW

The completion guide is the companion to the Health Careers and Nursing Immunization and Health Requirement Form. Most requirements are universal; however, please see your program manager for program specific requirements prior to proceeding. The Health Careers and Nursing Immunization and Health Requirement Form is an *optional* tool in managing health requirement information. Documentation from your health care provider is an acceptable alternative if it provides the same information as shown in the official form.

Once you have obtained the required immunizations, your documents must be uploaded to Qualified First/Verified Credentials. Do not attempt to create an account or upload documents *until* you have received your program specific code from your health career program. It is highly recommended that you attend an Immunization and Health Requirement Workshop before establishing your Qualified First/Verified Credentials Account. Workshop schedule and registration available at http://www.tri-c.edu/programs/health-careers/

What is a titer?

A titer is a blood test that checks your immune status to specific diseases. In reference to MMR and Varicella, a positive result indicates that you have immunity and do not require an additional vaccine. A negative or equivocal result for any of these diseases indicates that you may need additional doses of the vaccine.

TITERS AND IMMUNIZATIONS

①

MMR TITER (MEASLES, MUMPS, RUBELLA) **TITER IS REQUIRED**

- A positive result indicates immunity. Your healthcare provider must complete results, date and enter provider information.
- A negative or equivocal result for Measles, Mumps or Rubella does not satisfy this requirement.
    - If you have medically documented evidence of obtaining two vaccines for Measles and Mumps, and one vaccine for Rubella **or** two doses of MMR **in your lifetime,** you are compliant. Your healthcare provider must enter the dates of the vaccines and complete the provider information
    - If you do not have medically documented evidence of some or all of the required vaccines, you must obtain additional doses to be the equivalent of:
        - 2 doses of Measles vaccine
        - 2 doses of Mumps vaccine
        - 1 dose of Rubella vaccine

          Or
        - Two doses of MMR in lieu of the above

      Note: - doses must be administered 28 days apart based upon current CDC recommendations

▲ **denotes annual requirement**

VARICELLA (CHICKEN POX) **TITER IS REQUIRED** ②

- **A positive titer result** indicates immunity. Your healthcare provider must complete results, date and enter provider information**.**
- **A negative or equivocal titer result** for Measles, Mumps or Rubella **does not** satisfy this requirement
    - If you have medically documented evidence of obtaining two vaccines for Varicella **in your lifetime** in addition to the titer, you are compliant. Your healthcare provider must enter the dates of the vaccines and complete the provider information.
    - If you ***do not*** have medically documented evidence of obtaining two vaccines for Varicella, you must obtain additional dose(s) as warranted to meet the requirement.

HEPATITIS B (HEP B) (OPTION 3 DOSE SERIES **OR** POSITIVE TITER) ③

- A positive titer meets all Hep B requirements**.** Your healthcare provider must complete results date and enter provider information.
- **If unvaccinated,** obtain the 3 dose series administered at 0, 1, and 6 months. Your healthcare provider must document vaccination dates, and enter provider information.
- **A negative or equivocal*** titer requires documentation of a three dose series. Your healthcare provider must complete results, date and enter provider information.

* Some clinical sites may require an additional three dose series for those with a negative titer. Check with your specific program.

TDAP (TETANUS-DIPHTHERIA-PERTUSSIS) (VACCINE) ④

- A documented dose of Tdap
    - If Tdap was obtained more than 10 years prior, a Td booster is required. Healthcare provider must complete dose date and booster date (if applicable) and enter provider information.

TB TEST (TUBERCULOSIS TESTING)

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- **A two-step (Double Mantoux) is required** initially (within the past twelve months of admission into a health career program). Obtain test 1, return 48-72 hours to have test read. Obtain test 2 one to three weeks after test 1 is administered, return 48-72 hours to have test read. Your healthcare provider must document dates, results and enter provider information**.**

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- **A one-step TB is required▲** in *subsequent* years following the initial two-step. Annually and prior to the one year anniversary of the last skin test, obtain a one-step TB skin test. Your healthcare provider must complete results, date, and enter provider information.

OR

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- **IGRA Blood Test - i.e. QuantifFERON Gold or T-Spot▲** (you may choose this option annually in lieu of the skin tests listed above.) Your healthcare provider must document results, date and enter provider information. **If positive due to latent tuberculosis, complete item 8**

AND

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- **Chest x-ray▲** is required for positive results due to latent tuberculosis disease. A chest x-ray is only required once every five years. Medical Provider Verification Statement required in conjunction with x-ray report. **Proceed to item 9**. In subsequent years following the chest x-ray only the Medical Provider Verification Statement is required **(item 9)** to confirm the absence of active TB.

9

- **Medical Provider Verification Statement▲** Required in combination with original x-ray and independently in subsequent years following a chest x-ray. Your healthcare provider must provide a statement that indicates there are no active signs of TB and enter provider information**.**

INFLUENZA VACCINE

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- **An Influenza vaccine (flu shot) ▲** is required annually between the months of August 1 – November 1. (Some program deadlines may differ, please verify with your specific program). You must provide document that includes your name, date and medical source, and receipt if from pharmacy, or your healthcare provider must document the date, and enter provider information.

PROGRAM SPECIFIC REQUIREMENTS (ALL OTHER'S PROCEED TO ITEM 15)

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- **Vision Exam** is required for the **Dental Hygiene, MLT, Phlebotomy and Optical programs** **ONLY.** Provider to enter date of exam and complete provider information located under item 12.

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- **Color Blindness Test is required for the MLT and Phlebotomy Programs** **ONLY**. Provider to enter date of exam and complete provider information.

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- **Dental Exam with Radiographic images Dental Hygiene** **ONLY.** Provider to enter date of exam and complete provider information.

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- **Pre-Exposure Rabies Vaccine Vet Tech** **ONLY.** Obtain the three-dose series according to the following schedule: Dose 1 - as appropriate; Dose 2 – 7 days after dose 1; Dose 3 – 28 days after dose 1. Your healthcare provider must document dates and enter provider information.

REQUIRED FORMS

HEALTH RELEASE FORM

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- The Health Release Form is required for all health career programs. Healthcare provider must enter provider information. Student must sign and date**. (Some health career programs may have additional physical requirements, please check with specific program).**

HEALTH INSURANCE ATTESTATION

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- The Health Insurance Attestation Form is required for all health career programs. Student must complete the form in its entirety sign and date. Students may be required to provide evidence of health insurance from clinical/practicum site during his/her clinical experience.

▲ **denotes annual requirement**

ADDITIONAL REQUIREMENTS

CPR

- Most health career programs require CPR certification. American Heart Association Basic Life Support for Health Care Providers is the **ONLY** acceptable certification. Documentation to be uploaded to the student's Qualified First/Verified Credentials account. Acceptable documentation includes:
    - Copy of front and back of CPR card with signature
    - Letter of certificate verifying completion of course
    - Digital Certificate with name and scan bar code

BUREAU OF CRIMINAL INVESTIGATION (BCI) CHECK

- Most health career programs require a criminal background check. The following URL provides general information about the background check http://www.tri-c.edu/programs/health-careers/general-bci-requirements.html Students ***should not*** obtain a BCI until instructed to do so by the respective program manager.

DRUG SCREEN

- Many health care facilities require student that attend their site be drug screened. Detailed information is available at the following URL http://www.tri-c.edu/programs/health-careers/documents/Drug%20Screening%20Policy.pdf Students ***should not*** obtain a drug screen unless instructed to do so by the respective program manager.

Health Careers and Nursing Immunization and Health Requirement Form

Name_____ Student #_____
Last *First* *Middle*

Program Name_____ Date of Birth _____

SEE THE ACCOMPANYING HEALTH REQUIREMENT COMPLETION GUIDE FOR STEP BY STEP INSTRUCTIONS

▲ = DENOTES ANNUAL REQUIREMENT

TITERS ARE REQUIRED FOR BOTH MMR (MEASLES-MUMPS-RUBELLA) AND VARICELLA

1. **MMR** TITER DATE: _____ (IF **NEGATIVE OR EQUIVOCAL** PROCEED TO VACCINE INFO)

RESULT: **MEASLES**- POSITVE/NEGATIVE/EQUIVOCAL (CIRCLE ONE)

VACCINE: DOSE 1 DATE: _____ DOSE 2 DATE: _____

RESULT: **MUMPS**- POSITIVE/NEGATIVE/EQUIVOCAL (CIRCLE ONE)

VACCINE: DOSE 1 DATE: _____ DOSE 2 DATE: _____

RESULT: **RUBELLA**- POSITIVE/NEGATIVE/EQUIVOCAL (CIRCLE ONE)

VACCINE: DOSE 1 DATE: _____ (ONLY ONE DOSE REQUIRED)

PROVIDER PRINTED NAME: _____

ADDRESS: _____ OFFICE PHONE: _____

PROVIDER SIGNATURE/CREDENTIALS_____ DATE: _____

2. **VARICELLA** TITER DATE: _____ (IF **NEGATIVE OR EQUIVOCAL** ENTER VACCINE INFO)

RESULT: **VARICELLA**- POSITVE/NEGATIVE/EQUIVOCAL (CIRCLE ONE)

VACCINE DOSE 1 DATE: _____DOSE 2 DATE: _____

PROVIDER PRINTED NAME: _____

ADDRESS: _____ OFFICE PHONE: _____

PROVIDER SIGNATURE/CREDENTIALS_____ DATE: _____

Health Careers and Nursing Immunization and Health Requirement Form

Name_____ Student #_____
Last *First* *Middle*

Program Name_____ Date of Birth _____

SEE THE ACCOMPANYING HEALTH REQUIREMENT COMPLETION GUIDE FOR STEP BY STEP INSTRUCTIONS

Hep B *(Hepatitis B)* ***Either*** *Hep B 3-dose series or positive titer is required. If Hep B titer is* ***negative or equivocal*** *documentation of a three- dose series is required.*

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HEP B TITER DATE: _____RESULTS: **HEP B** – POSITIVE/NEGATIVE/EQUIVOCAL (CIRCLE ONE)

DOSE 1 DATE: _____ DOSE 2 DATE: _____ DOSE 3 DATE: _____

PROVIDER PRINTED NAME: _____

ADDRESS: _____ OFFICE PHONE: _____

PROVIDER SIGNATURE/CREDENTIALS _____ DATE: _____

TDap *(Tetanus-Diphtheria-Pertussis)*

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TDAP DOSE 1 DATE: _____

TD BOOSTER DATE: _____ (REQUIRED 10 YEARS AFTER TDAP)

PROVIDER PRINTED NAME: _____

ADDRESS: _____ OFFICE PHONE: _____

PROVIDER SIGNATURE/CREDENTIALS_____ DATE: _____

Health Careers and Nursing Immunization and Health Requirement Form

Name_____ Student #_____
Last *First* *Middle*

Program Name_____ Date of Birth _____

Tuberculosis (TB)
Original two-step TB Mantoux - (Upon entry or no more than twelve months prior to program entry)

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STEP 1 DATE: _____ **STEP 1** READ DATE: _____ RESULTS: POS/NEG/EQUIVOCAL

STEP 2 DATE: _____ **STEP 2** READ DATE: _____ RESULT: POS/NEG/EQUIVOCAL

PROVIDER PRINTED NAME: _____

ADDRESS: _____ OFFICE PHONE: _____

PROVIDER SIGNATURE/CREDENTIALS_____ DATE: _____

Annual one-step TB ▲ (Annually following original two-step. Must be within twelve months of last TB skin test)

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STEP 1 DATE: _____ STEP 1 READ DATE: _____ RESULT: POS/NEG/EQUIVOCAL

PROVIDER PRINTED NAME: _____

ADDRESS: _____ OFFICE PHONE: _____

PROVIDER SIGNATURE/CREDENTIALS_____ DATE: _____

OR

IGRA blood test *i.e. QuantiFERON Gold or T-Spot* ***▲ (Annually if this option is utilized)***

7

TEST DATE: _____ RESULT: POSITIVE/NEGATIVE/EQUIVOCAL

PROVIDER PRINTED NAME: _____

ADDRESS: _____ OFFICE PHONE: _____

PROVIDER SIGNATURE/CREDENTIALS_____ DATE: _____

***IF TB Test is* POSITIVE**

Chest X-ray

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DATE OF X-RAY:_____ RESULT: _____ (ONLY ONE X-RAY REQUIRED)

AND

Medical Provider Verification Statement ▲ (Annually to confirm absence of active TB symptoms.)

9

DATE: _____ (OF STATEMENT FROM MEDICAL PROVIDER) **PROVIDER**

PRINTED NAME: _____

ADDRESS: _____ OFFICE PHONE: _____

PROVIDER SIGNATURE/CREDENTIALS_____ DATE: _____

Health Careers and Nursing Immunization and Health Requirement Form

Name_____ Student #_____
Last *First* *Middle*

Program Name_____ Date of Birth _____

Influenza Vaccine ▲ (Annually between August 1 – November 1) Confirm with specific program

VACCINE DATE: _____

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PROVIDER PRINTED NAME: _____

ADDRESS: _____ OFFICE PHONE: _____

PROVIDER SIGNATURE/CREDENTIALS_____ DATE: _____

Vision Exam (Dental Hygiene, MLT, Phlebotomy and Optical programs ONLY)

11 DATE OF EXAM: _____

COLOR BLINDNESS TEST **(MLT AND PHLEBOTOMY ONLY)**

DATE OF EXAM: _____

12

PROVIDER PRINTED NAME: _____

ADDRESS: _____ OFFICE PHONE: _____

PROVIDER SIGNATURE/CREDENTIALS_____ DATE: _____

Dental Exam** with Radiographic Images **(Dental Hygiene ONLY)

13 DATE OF EXAM: _____

PROVIDER PRINTED NAME: _____

ADDRESS: _____ OFFICE PHONE: _____

PROVIDER SIGNATURE/CREDENTIALS_____ DATE: _____

Pre-Exposure Rabies Vaccine (Vet Tech ONLY)

VACCINE #1 DATE: _____ VACCINE #2 DATE: _____

14 VACCINE # 3 DATE: _____

PROVIDER PRINTED NAME: _____

ADDRESS: _____ OFFICE PHONE: _____

PROVIDER SIGNATURE/CREDENTIALS_____ DATE: _____

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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 a Health Career/Nursing Program at Cuyahoga Community College.

Provider Signature: _____

Provider Printed Name:_____

Provider Address: _____

Provider Phone Number:_____

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

Student Signature:_____

Student Printed Name:_____ Date: _____

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Cuyahoga Community College

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:** _____