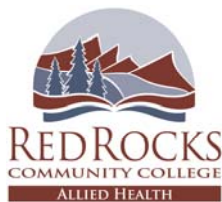


Registered Nurse (RN) Refresher, Nurse Aide, IV Certification, Phlebotomy, and Medical Assisting are required by the accreditation standards for health careers programs to document that the accepted student does not have health conditions which could endanger the health or well-being of patients, faculty or the student themselves. Please note that if you are pregnant we will need a doctor's note to attend clinicals.

In fulfillment of this requirement, you **must complete this packet and return to your instructor (see below).** A complete packet includes the following:

1. Obtain the immunizations or, as appropriate, document that you do not need the immunizations required by the program, as described below.

2. Document that you have had a negative TB test within the last year, as described below.

3. Undergo a physical examination at your own expense, at the medical facility or clinic of your choice and have the examining practitioner complete the attached certification form. Practitioners who are authorized to complete your certification form include any licensed physician, physician assistant practicing with a licensed physician, or an advanced practice nurse whose training is in adult or family practice.

4. Obtain BLS/CPR for the Healthcare Provider certification. It is ***required*** for all the above programs, but only recommended for the phlebotomy program.

5. You cannot begin the clinical portion of your program until these requirements are met and the documents you have submitted are approved by the program coordinator.

6. In the event that you are told or you believe that you may have a condition, which could endanger the health or well being of patients, faculty, other students or you yourself, immediately contact the program director.

Completed packets are due to instructors as follows:

Registered Nurse (RN) Refresher – First day of class
Nurse Aide – First day of class
IV Certification – First day of class
Phlebotomy – Before clinicals
Medical Assisting – Before clinicals

If you have any specific questions regarding this paperwork, please see your instructor the first day of class.

Tetanus Toxoid testing

All students shall present evidence of tetatanus immunization within 10 years of the beginning of any individual rotation. Persons who have confirmed allergy to tetanus toxoid immunization are excused from this requirement.

Date of most recent immunization ________________

(Attach verification signed by an authorized health care provider, including a registered nurse, physician assistant or physician)

Hepatitis B testing/immunity

Each student shall present evidence of successful completion Hepatitis B immunization or shall sign a wavier which indicates that he/she has been advised of the serious nature of Hepatitis B, but declines to accept Hepatitis B vaccination.

In lieu of the presentation of a vaccination record, student may present titers demonstrating Hepatitis B immunity. Students who decline immunization shall do so below.

Date of vaccinations:

___________________ _____________________ ______________________

(Attach verification of immunization or titers, signed by an authorized health care provider, including a registered nurse, physician assistant or physician)

Statement of Hepatitis B Immunization Declination

I, ______________________________, have been advised that infection by the Hepatitis B virus is a constant risk for health care students and workers including physician assistant students and graduates. I have been advised that the consequences of Hepatitis B infection are potently severe and may be life-threatening. Despite this information I have decided to decline immunization and accept the risk of Hepatitis infection. I release the state of Colorado, its elected and appointed officials and boards, the Community Colleges of Colorado, Red Rocks Community College, and its instructors, clinical instructors and employees from any liability associated with any infection of the Hepatitis B virus or its sequellae.

____ ____________________

Signature of student Date

WORKERS'S COMPENSATION
EMPLOYEE NOTIFICATION

The Worker's Compensation statute allows the employer the right to select the physician for injured employees. Red Rocks Community College designates Concentra Medical Centers for medical care relating to all work-related injuries and illnesses.

If you are injured while on the job, you must provide written notice to the Campus Police department of your supervisor within four working days of the accident, pursuant to section 8-43-102 (1,CRS). The following outlines the steps that each employee must take if an injury or illness is incurred while on the job:

- Contact the Campus Police department (303-914-6394) as soon as the injury occurs.
- Complete an Employee Statement received from the Campus Police.
- Campus Police department will complete an Employer's First Report of Injury form.
- If medical attention is needed, you will be given a card and written authorization by the Campus Police that indicates medical facilities where you are able to obtain medical treatment.
- If medical treatment is sought, all related paperwork received from the medical provider needs to be returned to Human Resources.

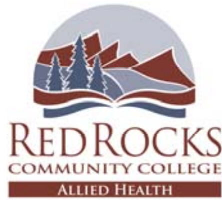
EMPLOYEE VERIFICATION

I have been notified by my employer of the procedure to follow in the event that I incur a work-related injury or illness. I understand that my employer has designated Concentra Medical Centers as the primary provider for all work-related injuries and illness. I understand that if I do not receive my medical care for work-related injuries and illnesses from Concentra, I will be financially responsible for that care.

I have been informed that written authorization is required from my employer before I access medical treatment for non-emergency, work related injuries and illnesses.

____
Print Name

____ ________________________
Signature Date



Immunization and Disease Record

Name of patient: ________________________________SS#/Student #:_______________

Program: ____ Semester: _______________

Measles, Mumps or Rubella

Students born after 1957:

Dates of no fewer than two MMR vaccinations at least one month apart at age 12 months or older: _________________ _________________ _________________

Student born before and during 1957:

Age contracted or date of exposure to:

Measles	_______________________
Mumps	_______________________
Rubella	_______________________
Chickenpox	_______________________

If there is significant doubt regarding such immunity, immune titers should be obtained. In lieu of written records of immunizations, students may present immune titers.

Tuberculosis testing

All students for whom there is no medical contraindication shall have a negative tuberculosis test no greater than 12 months prior to the beginning of any individual rotation: not to expire prior to completion of rotation. Any person with a positive tuberculosis test shall undergo chest x-ray. Persons for whom tuberculosis skin testing is contraindicated or inappropriate shall undergo chest x-ray in lieu of skin testing.

Date of test: _______________________ Result: _______________________________

(Attach verification signed by an authorized health care provider, including a registered nurse, physician assistant or physician)

IMMUNIZATION RECORD FOR HEALTH CAREER PROGRAMS
RED ROCKS COMMUNITY COLLEGE

Colorado Law and/or the clinical affiliates require all students enrolled in health career programs to provide documentation and dates of the following information. Therefore, please complete all non-shaded areas.

Student Name: ___________________________________ SS#/Student #: _________________________ DOB: ___________________

Select Program:

❑ Nurse Aide ❑ IV Certification ❑ Medical Assisting, Associate Degree ❑ Medical Assisting, Certificate ❑ Phlebotomy ❑ RN Refresher

TEST	**DATE RECEIVED**			**RESULTS**	**(For Office Use Only)**	
					YES	**NO**
MMR (Measles, Mumps, Rubella)						
TB/PPD				Positive* or negative *If positive PPD, please provide chest x-ray report.		
Tetanus						
Rubeola						
Hepatitis B	Series I	Series II	Series III			
Physician Statement						
CPR						

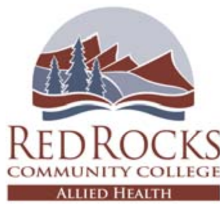
Record of Diseases: Have you ever had the following disease(s)? Please state the date and age you had the disease.

	Measles	Mumps	Chickenpox
DATE			
AGE			

I affirm that I have answered all of the previous questions to the best of my ability. I have completed the vaccination record above by using the *attached documentation* received from the health care facility that administered the vaccinations.

____ _______________

Student Signature Date



Health Care Provider's Certification of Student's Health

Instructions for providers:

The person whose name and social security number appears below has been extended an offer of admission into one of the following programs: Registered Nursing (RN) Refresher, Nurse Aide, IV Certification, Phlebotomy, and Medical Assisting at Red Rocks Community College. To matriculate in the program, it is necessary for the candidate to demonstrate that he/she is free of any medical conditions that could endanger the health or well being of patients or students.

At the expense of the student, please interview and examine this prospective student, and complete the form below. In the event that you feel the patient does have a health condition which could endanger the health or well being of patients, faculty or students, please discuss that condition with the patient and instruct the patient to call the Health Careers Program office at 303-914-6621 for further instructions.

Statement of Health Care Provider

Name of patient: ________________________________ SS#/Student #: ________________

I understand that the above-named patient has tentatively extended an offer of admission to a health care training program.

Following an appropriate history and physical examination, it is my opinion that the above-named patient:

___ Does ***not*** have a health condition which could endanger the health or well-being of patients, faculty or students, including the patient himself/herself.

___ Does appear to have a health condition which could endanger the health or well-being of patients, faculty or students, including the patient himself/herself.

Print name of provider: _________________________________ Date: _______________

Provider' signature: ____________________________________ Degree: _____________
(MD, DO, PA, NP)

Telephone: _____________________________