Health Care Provider's
Certification of New Student's Health

Instructions for Providers:

The person bearing this form has been extended an offer of admission to one of the following programs at Red Rocks Community College:

Registered Nurse (RN) Refresher
Nurse Aide
Phlebotomy
Medical Assisting

To matriculate in the program, it is necessary for the candidate to demonstrate that he or she is free of any medical conditions that could endanger the health or well-being of patients or other students, or prevent him/her from performing the physical tasks of emergency medical care. Generally, the following tasks are required:

- Ability to be fitted with a respirator mask in case of continued exposure to an airborne pathogen;
- Ability to lift, carry and balance heavy loads;
- Ability to interpret written and oral instructions, calculate weight and volumes ratios, and read small print, all under stressful situations;
- Ability to use good judgment and remain calm in high stress situations;
- Ability to function efficiently throughout an entire work shift;
- Good manual dexterity, with ability to perform tasks related to patient care.

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 student does have a health condition which could endanger the health or well-being of patients, faculty or students, please discuss that condition with the student and instruct the student to call the appropriate program director as listed below for further instructions.

MOT Clinical Coordinator:
Stephanie Bacon 303-914-6289

Phlebotomy:
Linda Pace 303-914-6625

Nurse Aide:
Jennifer Bresnahan 303-914-6081

Please complete Health care form and have health provider sign and date.
Thank you!

Signature of student _____ Date _____

Name of patient: _____ Date of Birth: _____

I understand that the above-named patient has been 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.

___ Is pregnant, but has permission to attend and clinicals and waive immunizations at this time.

ADDITIONAL REQUIREMENTS

Please also provide documentation of the following tests/vaccinations:

1. Chicken pox or Varivax vaccination -- Date of illness or vaccination: _____

2. Tdap/Tetanus -- Date of last vaccination or booster: _____

(Must be within the last 10 years)

3. MMR -- Last vaccination or booster Date: _____ Date: _____

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.

4. Tuberculosis Testing (PPD only acceptable test, less than one year old)

Date Tested: _____ Date Read: _____ Positive/Negative (circle one)
If **positive,** date re-tested: _____ Date Read: _____ Positive/Negative (circle one)
If **positive**, date of Chest X-Ray: _____
If **positive**, start date/end date of treatment: _____

5. Hepatitis B Vaccine (3-shot series)

Date 1st vaccine received _____ Titer Date (if applicable): _____
Date 2nd vaccine received _____ Results: _____
Date 3rd vaccine received _____

6. Seasonal Influenza Vaccine -- Date of vaccination: _____

_____ _____
Signature of provider *Date*

_____ _____
Printed name of provider *Degree: MD, DO, PA, NP*

_____
Telephone number