RED ROCKS
COMMUNITY COLLEGE

Health Care Provider's Certification of Student's Health

(documentation of up-to-date immunizations must accompany this form and be current through the completion of the Internship)

Instructions for Providers:

The person bearing this form is in Phlebotomy or Medical Assisting Program at Red Rocks Community College:

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. 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 the ability to perform tasks related to patient care.

At the expense of the student, it is mandatory for the candidate to demonstrate that they do not have any medical conditions that could put the safety or well-being of patients or fellow students at risk. The prospective student will cover the cost of your assessment, so please conduct an interview and physical examination and fill out the form provided below. If you believe the student has a medical condition that could endanger the health of patients, faculty, or students, please discuss the matter with the student (Do Not Sign) and advise them to contact the appropriate Program Director via email: Celina.krumpholz@rrcc.edu.

Name of patient: _____Date of Birth: _____

I understand that the above-named patient is in a healthcare training program.

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

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

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

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

_____ _____

Signature of provider *Date*

_____ _____

The printed name of the provider *Degree: MD, DO, PA, NP*

_____

Telephone number

Both forms require a signature

RED ROCKS
COMMUNITY COLLEGE

Certification of Immunization
Must Remain Current Through Completion of Internship Hours.

Instructions for Office Staff: The individual who presents this form is enrolled in either the Phlebotomy or Medical Assisting program at Red Rocks Community College. In order to attend clinical skills classes, it is mandatory for the candidate to demonstrate that they do not have any medical conditions that could put the safety or well-being of patients or fellow students at risk. The prospective student will cover the cost of your assessment, so please conduct an interview and physical examination and fill out the form provided below. If you believe the student has a medical condition that could endanger the health of patients, faculty, or students, please discuss the matter with the student and advise them to contact the appropriate Program Director via email: Celina.krumpholz@rrcc.edu.

Name of patient: _____Date of Birth: _____

IMMUNIZATIONS

Please provide documentation of the following vaccinations:
1. Hepatitis B Vaccine (3-shot series)-Two Doses Required Prior To Clinical Courses

Date 1st vaccine received _____Titer Date (if applicable): _____
Date 2nd vaccine received _____Results: _____
Date 3rd vaccine received _____

*2. Chickenpox or Varivax vaccination -- Date of illness or vaccination: _____

*3 Tetanus -- Date of last vaccination or booster: _____ (Must be within the last 10 years)

*4. 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.

*5. Seasonal Influenza Vaccine -- Date of vaccination: _____

*6. Tuberculosis Testing -PPD, IGRA(Quantiferon or T-spot) **complete just prior to internship test must < 1 yr. 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: _____

*7. COVID Vaccine: Brand_____ Date:_____ Date:_____

_____ _____
Signature of RN, LPN, or MA *Date*

_____ _____
Printed name *Degree: MD, PA, NP,RN, LPN, MA etc.*

_____ *Needed prior to internship
Telephone number

Both forms require a signature