RED ROCKS COMMUNITY COLLEGE

Health Care Provider's Certification of Student's Health

(To be completed prior to internship with documentation of up-to-date immunizations)

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 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 or Clinical Coordinator as listed below for further instructions.

Medical Office Technology/Phlebotomy Program Director: Linda Pace 303-914-6625

MOT/Phlebotomy Clinical Coordinator: Stephanie Bacon 303-914-6289

Name of patient: _____ Date of Birth: _____

I understand that the above-named patient is in 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.

_____ _____

Signature of provider *Date*

_____ _____

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

_____

Telephone number

Immunization Update on Next Page if Needed

RED ROCKS COMMUNITY COLLEGE

Certification of Immunization Prior To Clinical Classes

(MOT 138 or MOT 140)

And Prior to Internship

Instructions for Office Staff:

The person bearing this form is enrolled to one of the following programs at Red Rocks Community College: Phlebotomy or Medical Assisting

To participate in clinical skills classes, 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.

At the expense of the student, please update, document immunizations, and complete the form below. In the event that you feel the student cannot complete the necessary immunizations, please contact:

MOT/Phlebotomy Director: Linda Pace 303-914-6625
MOT/Phlebotomy Clinical Coordinator: Stephanie Bacon 303-914-6289

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. Chicken pox 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 only acceptable test; **complete just prior to internship as 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: _____

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

_____ _____
Printed name *Degree: RN, LPN, or MA*

_____
Telephone number

*Needed prior to internship