Red Rocks Community College

RN Refresher Program

STATEMENT FROM HEALTHCARE PROVIDER

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 verify and provide documentation of completion of the following tests/vaccinations:

1. Varicella vaccination, positive immune titer or reliable history of varicella infection
   Date of varicella infection_____ -OR-
   Date of positive immune titer _____ -OR-
   Date of vaccination _____
2. Tetanus/diphtheria/pertussis (Tdap) vaccination
   Date of vaccination_____
3. MMR vaccination
   A. If born on or after 1957, two MMR vaccinations at least one month apart
      Date of 1st MMR vaccination _____
      Date of 2nd MMR vaccination _____

   B. If born before1957, one dose MMR vaccine or positive measles, mumps and rubella titers
      Date of positive titer _____ -OR-
      Date of MMR vaccination _____
4. Negative PPD test (within 12 months)
   Date Tested _____ Date Read _____ Positive/Negative (circle one)
   If **positive,** date re-tested_____ Date Read _____Positive/Negative (circle)
   If **positive**, date of Chest X-ray_____ Positive/Negative (circle one)
   If **positive**, start date and end date of treatment _____
5. Completed Hepatitis B Vaccinations (3 in a series)
   Date 1st vaccine _____ Titer Date (if applicable): _____
   Date 2nd vaccine _____ Titer Results _____
   Date 3rd vaccine _____
6. Seasonal Influenza Vaccine
   Date of vaccination _____

_____ _____
Signature of healthcare provider *Date*

_____
Printed name of healthcare provider *Circle one: MD, DO, PA, NP*

9/12/14