RED ROCKS COMMUNITY COLLEGE
PHYSICIAN ASSISTANT PROGRAM

Student Health and Immunization Record

Instructions for students:

Health screening and immunization requirements for the Physician Assistant Program are based on current Centers for Disease Control recommendations for health professionals and are designed to promote and maintain the health and safety of students, faculty, patients and other health care providers.

Students must provide:

1. Immunization/immunity documentation (see form).
2. A negative TB test (PPD) or other acceptable evidence of negative TB status (see form).
3. Annual documentation of a health screening determination. The exam is performed at the student's expense by a licensed physician, a physician assistant practicing with a licensed physician or an advanced practice nurse whose training is in adult or family practice.

All completed forms must be personally delivered to the Program. All forms must contain original signatures (no photocopies or stamps). Students may not attend classes or begin clinical rotations unless all required forms are completed and delivered to the Program.

Any student who believes they have a condition which may be contagious or present a potential health hazard to patients, faculty, students or other health care providers, should contact the Program Director for instructions on how to have their situation reviewed by a designated Health Consultant.

Instructions for providers:

The Red Rocks Physician Assistant Program requires students to demonstrate he or she is free of any medical or psychiatric conditions which could endanger the health or well-being of patients, faculty, other health care providers, or students.

At the expense of the student, please conduct an appropriate history and physical exam and complete the form attached. In the event that you feel the student has a health condition which could endanger the health or well-being of patients, faculty, other health care providers or students, please discuss that condition with the student. The student should contact Christa Dobbs, MPAS, PA-C, Program Director at 303-914-6285.

RED ROCKS COMMUNITY COLLEGE
PHYSICIAN ASSISTANT PROGRAM

Immunization and Disease Record

Last Name: _____ **First Name:** _____ **MI:** _____

Waivers of immunizations due to documented allergies or declined as allowed by state law must be presented to the Program on a signed and notarized form. Please contact the Program for specific instructions. Additionally, please note that declined immunizations may exclude the student from certain health care facilities and the ability to fulfill the requirements of the Program.

Tuberculosis

The student must have a negative tuberculosis test (PPD) within 90 days of matriculation and within 12 months prior to the beginning of any clinical rotation. Any student with a positive tuberculosis test (PPD) or with contraindications for TB skin testing must have documentation of a recent chest x-ray showing no indications of active TB. (Attach verification document signed by an authorized health care provider.)

Measles, Mumps, and Rubella

Documentation of immune titers may be presented in lieu of records of these immunizations.

Dates of two **MMR** vaccinations at least one month apart at age 12 months or older:

_____ _____

Varicella

Documentation of immune titers may be presented in lieu of immunization records.

Date of Varicella vaccination: _____ OR

Age contracted Varicella/Chickenpox: _____

Influenza

CDC recommends yearly influenza vaccines for healthcare workers. Student must present documentation of influenza immunization the fall of each year enrolled.

Last Name: _____ **First Name:** _____ **MI:** _____

Tetanus / Pertussis

Student must document tetanus toxoid with pertussis immunization within 10 years of the beginning of any individual rotation. Persons who have a documented allergy to tetanus toxoid immunization are waived. Anyone with a Td only vaccination must receive vaccination with Pertussis component (Tdap).

Date of most recent immunization: _____

Hepatitis B

Student must document Hepatitis B series of three immunizations or titers demonstrating Hepatitis B immunity. (Attach verification of immunization or titers, signed by an authorized health care provider.)

Dates of vaccinations: _____ _____ _____

HBSAb titer if Hepatitis B series was > 10 years ago: _____

Health Care Provider's Certification of Student's Health

I have conducted an appropriate history and physical examination and find that

_____ (name)

DOES NOT or **MAY** (circle one)

have a health condition which could endanger the health or well-being of others.
If "May" was circled, I have provided counseling regarding the condition.

Printed name of provider: _____ **Date:** _____

Provider's signature: _____ **Degree:** _____
(MD, DO, PA, NP)

Telephone: _____

Revised: September, 2017

Flu Shot Verification Form

Student Information:

Name: _____ Date of Birth: _____

Student ID#: _____

Address: _____

For Clinic/Office Use only

Screening Questions

1. Is the Patient sick today? Y N
2. Does the patient have an allergy to eggs or any other component of the vaccine? Y N
3. Has the patient ever had a serious reaction to the flu vaccine? Y N
4. Has the patient ever had Gillian-Barre syndrome? Y N

Vaccine Information:

Vaccine Administered (Trade name) _____ Vaccination Date: _____

Vaccine Lot#: _____ Location: R___ L___

Name and Title of Vaccinator (Please Print): _____

Signature of Vaccinator: _____ Date: _____

RED ROCKS COMMUNITY COLLEGE
Student Health Clinic
303-914-6655

Tuberculosis Screening Form

Student Name _____ Date _____

Student ID# _____ DOB _____ Phone ____ - ____ - _____

Complete Address _____

Answer Yes or No to each of the following:

1. Have you ever been exposed to Tuberculosis? _____
2. Have you come in contact with an infected individual with in the past 6 months? _____
3. Have you received the BCG vaccine (vaccination for TB often given in foreign countries)? _____
4. Have you lieved outside of the United States for an extended period of time (>6 months)? _____
5. Do you have any medical conditions that suppress your immune system such as HIV/AIDS, Cancer, or take an Immunosuppressive medication such as Prednisone? _____
6. Have you ever had a positive skin test for tuberculosis? _____

IF yes to question 6, you may be referred for a chest X-Ray regardless of TB PPD results

PPD results

Date PPD Applied: _____ Placement: R ____ \L _____

Date PPD Read: _____ Size of Induration (in mm): _____ Positive \ Negative

Read By (Health Professional's Name): _____

Health Professionals Signature: _____