Health History (no physical exam required)

Name: __________________________________________

Street: __________________________________________

City: ______________________________ State: ____ Zip: ______________________

Phone #: ___________________________ Birth Date: __________________________

Student ID #: ______________________ Date Starting Program: _______________

Program:

☐ Associate Degree Nursing ☐ Medical Assistant ☐ Phlebotomy
☐ Dental Assistant ☐ Nursing Assistant ☐ Practical Nursing
☐ Dental Hygienist ☐ Occupational Therapy Assistant ☐ LPN to RN Pathway
☐ EMT-Basic ☐ Paramedic ☐ RN Refresher
☐ Health Information Technology

Where are you taking your class? (circle one) Appleton Oshkosh Chilton
Clintonville Waupaca other location ______________________

Have you been enrolled in another program at FVTC in the past? (circle one) Yes No
If yes, which program: __________________________________

Do you have any allergies including latex? If yes, please list and explain.
______________________________________________________________________________

Do you have or have you ever had the following?

Chicken Pox: Yes: ________ No: ________ Date of disease: ______________________

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back injury or problems</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Contusions or blackouts</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Diabetes</td>
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<td>☐</td>
<td>☐</td>
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<tr>
<td>Emotional problems</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Heart disease</td>
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<td>☐</td>
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<tr>
<td>Hepatitis</td>
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<td>☐</td>
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<td>☐</td>
</tr>
<tr>
<td>Immune deficiency</td>
<td>☐</td>
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<td>☐</td>
<td>☐</td>
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<tr>
<td>Kidney or bladder problems</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Muscle or bone problems</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Major surgery</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Recurrent severe headaches</td>
<td>☐</td>
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<td>☐</td>
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<tr>
<td>Rheumatic fever</td>
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<td>☐</td>
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<tr>
<td>Tuberculosis</td>
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<td>☐</td>
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<td>☐</td>
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<tr>
<td>Other severe illness</td>
<td>☐</td>
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</tbody>
</table>

For each yes above, explain:
______________________________________________________________________________

Please mail or drop off:
Fox Valley Technical College – Health Service
1825 N. Bluemound Drive, P.O. Box 2277
Appleton, WI 54912-2277
Phone #: (920) 735-5745 Fax #: (920) 831-4398, E-mail: montour@fvtc.edu

revised 10/2014
Student Name: ___________________________ Student ID #: ____________________

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**Tuberculin Skin Testing**

**IMPORTANT – Complete TB Tests BEFORE getting MMR or Varicella SHOTS**

**Tuberculin skin test:** Is there history of a positive skin test? Yes ______ No ______

**If positive TB test:** a chest x-ray or TB blood test must be done when entering the program and a copy of the chest x-ray report or lab report for tb blood test must be attached to this form.

*A two-step Mantoux intradermal tuberculin skin test is required.*

SEE PAGE 5 FOR DIRECTIONS

**Name of clinic/facility administering TB test:** ________________________________

TB tests done at FVTC are documented on a separate form.

**Test #1**

<table>
<thead>
<tr>
<th>Date #1 applied:</th>
<th>Time:</th>
<th>AM</th>
<th>PM</th>
<th>Site of injection:</th>
<th>Left</th>
<th>Right</th>
<th>Forearm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Manufacturer Expiration date: _________ Lot #: _________ MDV* Expiration Date: _________

Signature of person applying the skin test: __________________________________________

<table>
<thead>
<tr>
<th>Date #1 read:</th>
<th>Time:</th>
<th>AM</th>
<th>PM</th>
<th>Test Results:</th>
<th>mm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature of person reading & interpreting skin test: __________________________________________

*Multi Dose Vial

**Test #2**

<table>
<thead>
<tr>
<th>Date #2 applied:</th>
<th>Time:</th>
<th>AM</th>
<th>PM</th>
<th>Site of injection:</th>
<th>Left</th>
<th>Right</th>
<th>Forearm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Manufacturer Expiration date: _________ Lot #: _________ MDV* Expiration Date: _________

Signature of person applying the skin test: __________________________________________

<table>
<thead>
<tr>
<th>Date #2 read:</th>
<th>Time:</th>
<th>AM</th>
<th>PM</th>
<th>Test Results:</th>
<th>mm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Signature of person reading & interpreting skin test: __________________________________________

*Multi Dose Vial
**Immunizations**

Attach proof of vaccination

SEE PAGE 6 FOR DIRECTIONS

Seasonal Influenza Vaccination date: ________________ Classes running November thru March

**Varicella Immunizations (chicken pox)**

Proof of immunity to chicken pox is required by either 2 doses of vaccine or blood titer test. **NOT REQUIRED FOR NURSING ASSISTANT PROGRAM**

Dates: Dose 1 ________________ Dose 2 ________________ (attach proof of vaccine)

**Tdap** Date: ________________ (attach proof of vaccine)

**Measles Mumps Rubella (MMR) Vaccine 2 doses (no baby books) OR Immune titer tests**

- **Dose 1** Date vaccine given: ________________ **Dose 2** Date vaccine given: ________________
  Attach proof of vaccine

OR

**Titer Test Results**

<table>
<thead>
<tr>
<th>Titer Test</th>
<th>Month/Date/Year</th>
<th>(see directions page 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rubeola titer date (measles):</td>
<td>________________</td>
<td>Attach lab report</td>
</tr>
<tr>
<td>Rubella titer date (German measles):</td>
<td>________________</td>
<td>Attach lab report</td>
</tr>
<tr>
<td>Mumps titer date:</td>
<td>________________</td>
<td>Attach lab report</td>
</tr>
<tr>
<td>Varicella titer date:</td>
<td>________________</td>
<td>Attach lab report</td>
</tr>
</tbody>
</table>

**Hepatitis B (vaccine is optional)**

Most consider health care workers to be at increased risk for contracting Hepatitis B. Students are encouraged to discuss this vaccine with their health care provider. This is not a requirement, however, vaccine is strongly encouraged. You may start the vaccine series at any time.

*Please complete important Hepatitis B vaccine documentation on page 4.*
HEPATITIS B VACCINE DOCUMENTATION

I understand that as a student in a health profession educational program, and due to my educational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection, a serious disease. Please initial the ONE statement below that explains your situation.

_____ I have begun the vaccination series (three doses given over six months). I understand that because I have not completed the series and have not gotten the antibody screen, I continue to be at risk for acquiring HBV, a serious disease. Submit documented immunization record to your school.

   Date of vaccine #1: ______________________
   Date of vaccine #2: ______________________
   Date of vaccine #3: ______________________

_____ I have completed the vaccination series and I decline to complete the HBV titer. A titer is a blood test which measures antibodies. Contact your health care provider to schedule a lab appointment if needed. Submit documented immunization record to your school.

   Date of vaccine #1: ______________________
   Date of vaccine #2: ______________________
   Date of vaccine #3: ______________________

_____ I have completed the vaccination series and the HBV titer. My titer results indicated immunity to HBV. Submit documented immunization record to your school.

   Date of vaccine #1: ______________________
   Date of vaccine #2: ______________________
   Date of vaccine #3: ______________________
   Date of titer: ______________________

_____ I have completed the vaccination series; however, my HBV titer showed I am not immune. I understand that because I have not converted to HBV immunity, I may be at risk for acquiring Hepatitis B, a serious disease. I understand that it is recommended that I receive a booster vaccine of Hepatitis B because of my educational exposure to blood or other potentially infectious materials.

   Date of Titer: ______________________ Submit documented immunization record to your school.

_____ I have repeated the vaccination series and/or a booster vaccine. Submit documented records to your school.

   Date of vaccine #1: ______________________
   Date of vaccine #2: ______________________
   Date of vaccine #3: ______________________
   Booster vaccine: ______________________
   Date of titer: ______________________
   Date of second titer: ______________________

_____ I decline the Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk for acquiring Hepatitis B, a serious disease. If in the future I continue to have educational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can then be made aware of the various options available to me for the vaccination and documentation of immunity. I understand that I have the option to rescind this declination at any time if I wish to proceed with the vaccination series.

By my signature below I acknowledge that I have been made aware of the measures to prevent HBV infection, and I will not hold my educational institution or any clinical agency accountable for acquired HBV infection.

_________________________  ____________________________________________________________________
Printed Name                                                Signature                                                                                  Date

_________________________  ____________________________________________________________________
Student ID#
Health Requirements Information

FVTC is required to provide proof to our clinical agencies that our students enrolled in health programs will not be exposing their residents/patients to any illness or disease. Therefore, each student will need to complete the following documentation either before class orientation or by the date given to you by your academic counselor or advisor. Failure to comply may result in dismissal from class without a refund.

- The FVTC health history form
- Verification of immunity to measles, mumps and rubella (in English) see page 6 for directions
- Verification of immunity to varicella (chicken pox) EXCEPT CNA STUDENTS
- Tdap booster within last 10 years.
- Seasonal influenza vaccination – if in clinical site November 1 thru March 31
- 2-step Mantoux tuberculin skin test. Provider verified proof you do not have communicable disease (tuberculosis). (see directions below)

Provider verification means written proof of where and when you received your immunizations and TB testing. Acceptable verification includes a signed immunization record or a printed record from a health department, or Wisconsin Immunization Registry (WIR), high school or clinic where the immunizations were received. Dates in books or records without official signatures, (baby books or foreign language) are not acceptable.

Health History Form
Submit completed health history form, immunization information, titer lab report/s and any other pertinent or requested information to the College Health Service office, room A164 on the Appleton campus.
Please submit information to:
FVTC Health Service
1825 N. Bluemound Drive, PO Box 2277
Appleton, WI  54912-2277   Phone# (920)735-5745   Fax#:  (920) 831-4398   E-mail: montour@fvtc.edu

Tuberculin skin test

Clinical agencies require a two-step TB skin test that will not expire during the clinical experience. This test consists of:

Test 1:  TB skin test is administered and read by a RN or health care designee 48-72 hours later.

Test 2:  At least one week after test 1 is administered, test 2 may be administered. Test 2 should be read 48-72 hours later by a RN or Health care designee. Attach documentation (of BOTH tests) to the FVTC health history form.

Please contact College Health Services, 920-735-5745 to schedule an appointment if you require TB testing. There is no charge for the TB tests done through the College Health Service if you are registered for a health class. YOU MUST MAKE AN APPOINTMENT.

If you are currently receiving an annual TB test
You must provide written documentation of the test results, last test being completed within the year, and will not come due during a clinical rotation AND documentation reflecting past 3 years of TB tests. Attach documentation to the FVTC health history form.
IMMUNIZATIONS (IN ENGLISH)

Seasonal Influenza Vaccination
- Flu vaccination is good for current flu season beginning in the fall
- Clinical sites require flu vaccination while available; year round
- If you are in a clinical setting at any time between November 1 and March 31, you need a flu shot or signed waiver from your physician or clergy.

Measles, Mumps, and Rubella (MMR)
Provider verification must document 2 doses of MMR vaccine with one of the doses being given after 1980 OR immune titers. The following guidelines may help you determine your status:
- If you were born prior to 1957 you probably had all 3 diseases, however you still need to prove immunity through either titers or immunizations.
- If you were born prior to 1969 you probably did not receive a combined vaccine for MMR or may not have had the disease.
- If you graduated from public school in Wisconsin in 1990 or later you were required by law to have 2 doses of MMR.

MMR vaccine is available through the College Health Service at no charge to students who have no health insurance and have negative titer test results.

Titers (copy of the laboratory report must be submitted with your health form)
Titers are blood tests that detect antibodies to Measles, Mumps, Rubella and Varicella disease. Titers are one way a student can prove immunity to disease if immunization records are missing or incomplete. These lab tests can be done through your doctor’s office or clinic. **NOTE:** these tests may not be covered under health insurance policies.

Tdap vaccine (tetanus/diphtheria and adult pertussis) Tdap is given once as an adolescent/adult over 11 years old and is required for all students.

Varicella (chicken pox) NOT REQUIRED FOR NURSING ASSISTANT PROGRAM
Provider verification must document 2 doses of varicella vaccine OR blood titer test proving immunity. If you have not had two immunizations, you will need to have a titer test. **History of disease is not accepted as proof of immunity.** If varicella titer is non-immune you will need to be vaccinated

Hepatitis B vaccine (OPTIONAL) Complete Hepatitis B Vaccine Documentation page 4
- Vaccine is not required but is strongly recommended for all health care workers.
- Vaccine is given in a series of 3 doses. This vaccine is available at a reduced fee for current students-contact College Health Services for more information.

Student will not be eligible to participate in clinical settings unless all health information is complete and approved by the College Health Service.

*These guidelines are subject to change, keeping in accordance with Fox Valley Health Care Alliance.*

Revised 10/2014