

Health History (no physical exam required)

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Birth Date: _____

Student ID #: _____ Date Starting Program: _____

Program:

- | | | |
|--|---|--|
| <input type="checkbox"/> Associate Degree Nursing | <input type="checkbox"/> Medical Assistant | <input type="checkbox"/> Phlebotomy |
| <input type="checkbox"/> Dental Assistant | <input type="checkbox"/> Nursing Assistant | <input type="checkbox"/> Practical Nursing |
| <input type="checkbox"/> Dental Hygienist | <input type="checkbox"/> Occupational Therapy Assistant | <input type="checkbox"/> LPN to RN Pathway |
| <input type="checkbox"/> EMT-Basic | <input type="checkbox"/> Paramedic | <input type="checkbox"/> RN Refresher |
| <input type="checkbox"/> 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: _____

	Yes	No		Yes	No
Back injury or problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or bladder problems	<input type="checkbox"/>	<input type="checkbox"/>
Contusions or blackouts	<input type="checkbox"/>	<input type="checkbox"/>	Muscle or bone problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Major surgery	<input type="checkbox"/>	<input type="checkbox"/>
Emotional problems	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent severe headaches	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Immune deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Other severe illness	<input type="checkbox"/>	<input type="checkbox"/>

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 10/1/2013

Student Name: _____ Student ID #: _____

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

Date #1 applied: _____ Time: _____ AM PM Site of injection: Left Right Forearm
Circle One

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

Signature of person applying the skin test: _____

Date #1 read: _____ Time: _____ AM PM Test Results: _____ mm

Signature of person reading & interpreting skin test: _____

*Multi Dose Vial

Test #2

Date #2 applied: _____ Time: _____ AM PM Site of injection: Left Right Forearm
Circle One

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

Signature of person applying the skin test: _____

Date #2 read: _____ Time: _____ AM PM Test Results: _____ mm

Signature of person reading & interpreting skin test: _____

*Multi Dose Vial

Student Name: _____ Student ID #: _____

Immunizations
Attach proof of vaccination

SEE PAGE 6 FOR DIRECTIONS

Seasonal Influenza Vaccination date: _____ Classes running October 1 thru March 31

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 **Month/Date/Year** (see directions page 6)

Rubeola titer date (measles): _____ *Attach lab report*

Rubella titer date (German measles): _____ *Attach lab report*

Mumps titer date: _____ *Attach lab report*

Varicella titer date: _____ *Attach lab report*

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.
- 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 a year
- Clinical sites require flu vaccination while available; year round
- If you are in a clinical setting at any time between October 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.