Oregon Coast Community College Health Form

Student/Faculty Name:

Program:

These requirements are in place for the health and safety of students, faculty and their patients.

By contract with your academic institution, all students and faculty participating in patient care experiences must meet the following health and safety requirements. The academic institution is responsible for ensuring that requirements have been met **prior** to participation in patient care/clinical experience. Records will be kept at the academic institution and random review by the clinical affiliates will occur on a regular basis. *Documentation must meet requirements at all times.*

If you obtained your vaccine through an Oregon Public Health Department or through a school district in Oregon, after 1980 then you are probably in the ALERT system that is maintained by Public Health. Please call or visit your local Public Health Department as they may help you in obtaining the need documentation.

SUBMITTED ONCE

TUBERCULIN STATUS

- If no previous records or more than 12 months since last TST → **OR**
- QuantiFERON (QFT) TB Gold test within 12 months **OR**
- If newly positive TST → F/U by healthcare provider (chest X-ray, symptoms check and possible treatment documentation of absence of active M. TB disease) and need to complete health questionnaire
- If history of positive TST → provide documentation of TST reading, provide proof of chest X-ray documenting absence of M. TB, medical treatment and negative symptom check **OR**
- If history of BCG vaccine → QFT. If negative → OK; If positive → do Chest X-Ray, and symptom check by healthcare provider in 12 months

HEPATITIS B

- Series of 3 vaccines completed at appropriate time intervals **OR**
- Provide documentation of positive titer (anti-HBs) **OR**
- If titer is **negative or equivocal** Proof of vaccinations (3 doses at appropriate intervals dated AFTER the titer)

MEASLES, MUMPS, AND RUBELLA

- Proof of vaccination (2 doses at 28 days apart) **OR**
- Proof of immunity by titer
- If titer is **negative or equivocal** Proof of vaccinations (2 doses at appropriate intervals dated AFTER the titer)

VARICELLA (Chicken Pox)

- Proof of vaccination (2 doses at appropriate intervals) **OR**
- Proof of immunity by titer or
- Physician documentation of proof of disease

TETANUS, DIPTHERIA, PERTUSSIS (Tdap)

- Tdap **required** every 10 years **OR**
- Td (dated within the last 24 months) and Pertussis.

CPR

- American Heart Association BCLS Healthcare Provider Certificate

SUBMITTED EVERY YEAR

TUBERCULIN STATUS

- Previously documented +TST results and prior negative chest X-ray results: submit annual symptom check completed within one year from healthcare provider.

INFLUENZA

- Proof of annual vaccination(s)

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	SUBMITTED ONCE Check the applicable letter in each box		**SUBMITTED EVERY YEAR** Check the applicable letter in each box
	TUBERCULIN STATUS A. One-step TST: Skin Test Date_____Result: Neg___Pos___mm___ B. QuantiFERON (QFT) Date_____ Result:_____ **OR** C. If New Positive/Exam/X-ray Date:_____ **OR** D. Positive TST/Negative X-ray Date:_____		**INFLUENZA** A. Proof of annual vaccination(s) Date 1_____Date 2_____ **OR**
	HEPATITIS B (3 primary series shots: (at 0,1,6, mo) plus titer confirmation (6-8 weeks later) A. Vaccination Dates 1) _____ 2) _____ 3) _____ B. Immunity confirmed by titer Date_____		
	MMR (Measles, Mumps, Rubella**)** A. Vaccination Dates 1)_____ 2)_____ **OR** B. Immunity by titers: Measles Date_____ Mumps Date_____ Rubella Date_____		
	VARICELLA (Chicken Pox) A. Vaccination Dates 1)_____ 2)_____ OR B. Immunity by titer Date_____		
	TETANUS,DIPTHERIA, PERTUSSIS (Tdap) A. Tdap Date_____ B. Td Date_____ C. Pertussis: Date:_____ (if you obtained a Td)		
	CPR AHA BCLS Healthcare Provider Certificate Expiration Date _____		