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

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

COVID-19 VACCINE
A. Vaccination Dates
Dose #1) _______________
Dose #2) _______________

Product Name/Manufacturer ___________________
B. Other
Dose #1) ______________

Product Name/Manufacturer ___________________

SUBMITTED EVERY YEAR

INFLUENZA
A. Proof of annual vaccination
Date: ____________

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

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	Program:
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<table>
<tr><th colspan="2">SUBMITTED ONCE
Check the applicable letter in each box</th><th colspan="2">SUBMITTED ONCE
Check the applicable letter in each box</th></tr>
<tr><td></td><td><u>COVID-19 Vaccine</u>
A. Vaccination Dates
Dose #1) _______________
Dose #2) _______________

Product Name/Manufacturer ___________________

B. Other
Dose #1) ______________

Product Name/Manufacturer ___________________</td><td></td><td>TETANUS, DIPTHERIA, PERTUSSIS (Tdap)
A. Tdap Date: _________
B. Td Date: ___________
C. Pertussis: Date: ______________ (if you obtained a Td)

<u>CPR AHA BCLS Healthcare Provider Certificate</u>
Expiration Date: ________</td></tr>
<tr><td></td><td><u>HEPATITIS B</u> (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_____</td><td></td><td>SUBMITTED EVERY YEAR

<u>INFLUENZA</u>
A. Proof of annual vaccination
Date: _____________</td></tr>
<tr><td></td><td><u>MMR (</u><u>Measles, Mumps, Rubella</u><u>)</u>
A. Vaccination Dates
1)__________ 2) __________ OR

B. Immunity by titers: Measles Date: ___________
Mumps Date: _________ Rubella Date: _________</td><td></td><td><u>TUBERCULIN STATUS</u>
A. One-step TST: Skin Test Date_____ Result:
Neg___ Pos___ mm___

QuantiFERON (QFT) Date_____ Result: _____
OR
B. If New Positive/Exam/X-ray Date: _____
OR
C. Positive TST/Negative X-ray Date: _____</td></tr>
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