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.* Required immunizations must include mm/dd/yyyy.

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
Check the applicable letter in each box

COVID-19 Vaccine
A. Vaccination Dates
Dose #1) _____
Dose #2) _____

Product Name/Manufacturer _____

B. Other
Dose #1) _____
Product Name/Manufacturer _____

MMR (Measles, Mumps, Rubella**)**
A. Vaccination Dates
1)_____ 2) _____ **OR**

B. Immunity by titers: Measles Date: _____
Mumps Date: _____ Rubella Date: _____

Varicella (Chickenpox)
A. Vaccination Dates
1) _____ 2) _____ **OR**
B. Immunity confirmed by titer Date _____ **OR**
C. Verified Date of disease _____

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_____

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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: _____

TUBERCULIN STATUS
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: _____

SUBMITTED EVERY YEAR

INFLUENZA
A. Proof of annual vaccination
Date: _____