Oregon Coast Community College
Health Form& Compliancy Document

Student/Faculty Name:

Nursing Program (Allied Health – MA, NA, EMT)

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

By contract with your academic institution, all students and faculty participating in patient care experiences within the hospital and community settings 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 in order to attend clinical rotations and meet the outcomes of the courses and program.***

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 be able to help you obtain the required documentation.

Vaccinations

TUBERCULIN STATUS **Completed**_____

- On an annual basis you must provide:
- Proof of a negative PPD test,
- QuantiFERON (QFT) TB Gold test
- 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 **Completed**_____

- 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)

MMR **Completed**_____

- 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 **Completed**_____

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

TDAP **Completed**_____

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

CPR **Completed**_____

- American Heart Association BCLS Healthcare Provider Certificate
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COVID - 19 VACCINE **Completed**_____

- Primary Vaccination Dates and Product Name/Manufacturer
- Bivalent Booster Dates and Product Name/Manufacturer

INFLUENZA **Completed**_____

- Proof of annual vaccination

Additional Requirements

Criminal Background Check (annually)

- Prior to initial placement; but no more than three months before entry into a training program
- Date Complete _____

Substance Abuse – 10 panel Drug screen (annually)

- Prior to initial placement; but no more than three months before entry into a training program
- Date Complete _____

Individual Fingerprint Report – Fieldprint (annually)

- Prior to initial placement; but no more than three months before entry into a training program
- Date Complete _____

Verification of Fit Testing

- This is clinical site dependent.
- You will be informed if you must obtain this.
- Date Complete _____