Revised 6/2013

CTHSS
CONNECTICUT TECHNICAL
HIGH SCHOOL SYSTEM

FULL-TIME ADULT STUDENT

Acceptance Package

Phase II

THE FOLLOWING FORMS ARE NOT TO BE COMPLETED AND RETURNED UNLESS YOU ARE ACCEPTED INTO A PROGRAM

Connecticut Technical High School System

Student's Name _____ Student ID # _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Student's Home Phone _____ Cell _____ Alt/email _____

Emergency Contact Name _____ Phone (1) _____ (2) _____

( ) Aviation Maintenance Technician
( ) Licensed Practical Nurse
( ) Certified Nurse Assistant
( ) Medical Assistant
( ) Dental Assistant
( ) Surgical Technician

TO THE EXAMINING PHYSICIAN/HEALTHCARE PROVIDER: **Date of Exam:** _____

On the basis of my health assessment and physical exam: □ Student denies Latex Allergy

Student is clear to participate in clinical nursing courses *with no restrictions* (please check) □ Yes □ No

IF NO, please explain the nature of the restrictions/limitations related to the delivery of patient care:

_____

_____

_____

IMMUNIZATION ASSESSMENT

Please refer to the CDC *Healthcare Personnel Vaccination Recommendations* at http://www.immunize.org/catg.d/p2017.pdf

TITERS MUST BE POSITIVE PER LABORATORY STANDARD; REPORT MUST ACCOMPANY THIS FORM. If titers show student is not immune, please state plan of how non-immunity will be addressed.

RUBEOLA (MEASLES) TITER _____Immune? Yes ___ No ___
May be Qualitative or Quantitative Titer ***Laboratory report must be attached***

If No, include plan for or evidence of receipt of 2 doses of MMR Vaccine; refer to CDC guidelines
http://www.immunize.org/catg.d/p2017.pdf

RUBELLA (GERMAN MEASLES) TITER _____Immune? Yes ___ No ___
May be Qualitative or Quantitative Titer ***Laboratory report must be attached***

If No, include plan for or evidence of receipt of 2 doses of MMR Vaccine; refer to CDC guidelines
http://www.immunize.org/catg.d/p2017.pdf

MUMPS TITER _____ Immune? Yes_____ No _____
May be Qualitative or Quantitative Titer ***Laboratory report must be attached***

If No, include plan for or evidence of receipt of 2 doses of MMR Vaccine; refer to CDC guidelines
http://www.immunize.org/catg.d/p2017.pdf

VARICELLA (CHICKEN POX) Provide Evidence of Immunity by: ☐ Physician diagnosis ***or*** ☐ Titer ***or*** ☐ Lab confirmation of disease ***or*** ☐2 doses of varicella vaccine ≥ 28 days apart

May be Qualitative or Quantitative Titer ***Laboratory or physician report of diagnosis must be attached***

TETANUS/DIPHTHERIA/PERTUSSIS (Tdap/Td) Date of Tdap/Tetanus/Td Booster _____(date given must be within last 10yrs)

All healthcare personnel (HCP), regardless of age, should receive a single dose of Tdap as soon as feasible if they have not previously received Tdap and regardless of the time since last Td dose; then they should receive Td boosters every 10 years thereafter. For further information see: http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-td-tdap.pdf

ANNUAL ASSESSMENTS/REQUIREMENTS:

Hep. B SERIES: _____ _____ _____
Per protocol 1st dose 2nd dose 3rd dose

□ ***Student has been determined to be a non-responder and is aware of CDC recommendations for exposure to Hepatitis B surface antigen positive blood, refer to CDC guidelines*** **http://www.immunize.org/catg.d/p2017.pdf**

Hep. B Surface Antibody Titer _____ Immune? Yes _____No_____ **(if no, revaccinate with add'l 3 dose series)**

≥10mlU/ml is positive/Immune (1-2 months following Dose #3) ***Laboratory report must be attached***

TST (Tuberculosis Skin Test required yearly)
(TST must be performed in accordance with requirements of clinical facilities) _____ _____ _____
Date Given Date Read Results

If previously positive TST (Year 2 and forward) complete Annual TB screening form: ☐ Student shows no evidence of TB symptoms

If new positive TST provide: ☐ chest x-ray report showing no evidence of active TB disease ***Attach Official report(s)/record(s)***

Influenza Vaccination is required yearly; please provide evidence of vaccination per CDC protocol _____
Official report/record must be attached Date Given

_____ _____ _____ _____
Healthcare Provider Print Name **Healthcare Provider Signature** **DEA Number** **DATE**

Address: _____**Telephone** ( ) _____- _____

Connecticut Technical High School System

Student Statement of Responsibility

I understand that I must submit a completed Health Assessment form prior to participation in any clinical experiences.

I am aware that if my health status should change in a way that would impact my ability to perform in the nursing program, I must notify the Director/Administrator of the program immediately. The need for additional clearance will be determined at that time.

_____
Student Name (Please Print)

_____ _____
Student Signature Date

Connecticut Technical High School System

Annual Tuberculin Screening Form

Student Name: _____ Date: _____

History of Positive Tuberculin Skin Test: ☐ YES ☐ NO

History of BCG Vaccine: ☐ YES ☐ NO

Date of last chest x-ray: _____ Results: _____

Current Symptom Assessment:

Signs and symptoms of active TB: ☐ YES ☐ NO

If yes, indicate medical treatment plan:

_____

_____

_____

Student is cleared to attend clinical assignments with no restrictions: ☐ YES ☐ NO

_____ _____
Primary Care Provider (Print Name) Date

_____ _____
Primary Care Provider Signature Telephone Number

_____
Street Address

_____
City State Zip Code

Information for Students and Healthcare Providers about Immunity Assessment/Titers for Nursing Students

MMR: **the MMR titers once determined do not have to be rechecked, regardless of when drawn**. It is possible that they may be lowered during pregnancy, but otherwise should remain consistent. In this case a *qualitative* titer is acceptable. In a situation whereby a student was vaccinated in year one of the program, titers should be validated in year 2 of the program.

Varicella: *Quantitative* titers should be drawn once; **if immunity is determined to be present then student does not need titer drawn for second year.** In any case if student is immunized year 1 then titer should be drawn year 2, the key is QUANTITATIVE titer vs. qualitative (i.e. EIA index is not a quantitative titer).

Hepatitis B: Very Tricky. Some people NEVER develop immunity; some can lose immunity over time, thereby requiring a booster. So with this in mind:
Those students that go through their series of injections during or in preparation for year one of the program, should then go on to have a QUANTITATIVE test for year 2. This value must exceed 10 milliunits / ml to establish immunity. If immunity is not established, the student should have a booster and have immunity rechecked.

If a student produces a recent titer (less than 5 years old) that establishes immunity this will suffice for both years. In the event that a student produces a titer 5 years or older a quantitative titer is required for year 1.

The student that comes to us stating they have had the series in the past, regardless of proof of the shots, still need to have a quantitative titer done to establish immunity. For all intents and purposes for any student (even those who are readmitted or transferred) this should suffice as long as we were within a 5 year window of time from the initial establishment of immunity.
If a student refuses to receive Hepatitis B immunization a waiver must be signed and kept on file.

PPD: Must be updated on a yearly basis in order to maintain status in the program, exceptions:
Students who have received BCG immunization should not get a PPD
Students who have had a positive PPD
Students who are immunosuppressed, have cancer, or are on steroids should not get a PPD

If PPD cannot be obtained because of the above, student should have a SINGLE chest x-ray to document freedom from disease. Thereafter, on a yearly basis, a note must be received from the Healthcare provider stating that the student shows no evidence of symptoms of TB.
Source: Quest Diagnostic Laboratory, July 2004

REFUSAL FOR USE OF HEPATITIS B VIRUS VACCINE

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. However, I decline hepatitis B vaccination at this time. I understand that by declining this hepatitis B vaccination at this time, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can then receive the vaccination series.

NAME: _____ DATE: _____

WITNESS: _____ DATE: _____

Healthcare Personnel Vaccination Recommendations

Healthcare Personnel
Vaccination Recomme

TB Screening Form.pdf