☐ Dental Hygiene
☐ Medical Assistant
☐ Nursing
☐ Radiography
☐ Respiratory Care
☐ Sonography

NORTHAMPTON COMMUNITY COLLEGE

**HEALTH FORM**

**SELECTIVE ADMISSION PROGRAMS**

*For questions about health requirements, please contact:*

**Health and Wellness Center**

**Northampton Community College**
College Center, Room 120
3835 Green Pond Road
Bethlehem, PA 18020

**Phone: 610-861-5365**

## PART I – REPORT OF MEDICAL HISTORY

Please complete *(print all sections)*. **International students: please provide all health documents translated into English.**

**Student Name**: _____ **Student ID #:** _____
*Last First Middle*

Home Address: _____ Gender: ☐ Male ☐ Female ☐ Other _____

City/State/Zip: _____ Preferred: ☐ He/Him ☐ She/Her ☐ They/Them

Home Phone: _____ Cell Phone: _____

Email Address: _____ **Date of Birth**: _____

Program/Major: _____ On Campus Housing: ☐ Yes ☐ No

Semester: ☐ FA ☐ SP ☐ SU Year _____ Campus: ☐ Main ☐ Fowler ☐ Monroe

### I. EMERGENCY NOTIFICATION

Name of Contact: _____ Relationship: _____
Home Address: _____ City/State/ Zip: _____
Primary Phone: _____ Alternate Phone: _____

### II. MEDICAL HISTORY – Please answer yes or no to all questions and insert the year for all positive answers:

| | Yes | No | Please Explain |
|---|---|---|---|
| Allergies | | | |
| Asthma | | | |
| Cardiac | | | |
| Chemical Dependency | | | |
| ▪ Drugs | | | |
| ▪ Alcohol | | | |
| Diabetes Mellitus | | | |
| Gastrointestinal Disorder | | | |
| Hearing Disorder | | | |
| Hypertension | | | |
| Neuromuscular | | | |
| Orthopedic Condition | | | |
| Respiratory Illness | | | |
| Seizure Disorder | | | |
| Vision Disorder | | | |
| Other (Specify) | | | |

**ACCIDENT AND HEALTH INSURANCE (Required) –** Student must upload a copy of current health insurance card (front and back) to myRecordTracker®. Student is required to have valid health insurance for the duration of the program and must notify the Program Director and the Health and Wellness Center of any change in health insurance which occurs during the program, and upload a copy of the new insurance card.

*If the above-named emergency contact cannot be reached at the time of an emergency, the College is authorized to send the above-named student to the nearest hospital and/or to administer necessary emergency care. In addition, I authorize the release of information regarding my health/medical status to the Program Director and appropriate designee(s), to the Northampton Community College Health and Wellness Center, to the appropriate health care agency in which I am completing clinical requirements, and/or to the above-named emergency contact.*

_____ _____
*Student signature (Parent/Guardian if under 18 years of age)* *Date*

## PART II-REPORT OF MEDICAL EXAMINATION

A physical examination completed **within 6 months of the start of the clinical experience** by a licensed medical provider (MD, DO, CRNP, or PA-C) is **required** prior to entry into clinical practice. Clinical work is **PROHIBITED** until the required medical forms are uploaded and verified.

**Name:**_____ **Student ID:**_____ **DOB:**_____

**I.** Height_____ Weight_____ Blood Pressure_____ Pulse_____

**II.** Vision Uncorrected R_____ L_____
Corrected R_____ L_____

**III.** Clinical Examination: *Describe details of abnormalities* **Date of Examination**:_____

| | Normal | Abnormal | Comments |
|---|---|---|---|
| Skin | | | |
| Head and scalp | | | |
| Eyes | | | |
| Ears/Hearing | | | |
| Mouth, Nose, Throat | | | |
| Neck | | | |
| Heart | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitourinary | | | |
| Musculoskeletal | | | |
| Neurological | | | |
| Psychiatric | | | |
| Exposure to Hepatitis A, B, or C | | | *If positive for exposure, please submit titers.* |

| | |
|---|---|
| Allergies | |
| Medications taken on a regular basis | |

| ****IMPORTANT** LICENSED PROVIDER, PLEASE INITIAL TO CERTIFY THE FOLLOWING:** | **INITIALS** |
|---|---|
| I certify that the applicant is free from communicable diseases in the communicable state. | |
| I certify that the applicant has no medical conditions or restrictions which will prevent the applicant from performing the essential functions of the job. (If the applicant has restrictions that require accommodation, please note them in the comments section below.) | |
| Comments *(if applicant has any limitations, please explain)*: | |

***Please print, type or stamp:***

Name of Licensed Provider_____

Address:_____

Signature of Licensed Provider_____ Date_____

# CLINICAL REQUIREMENTS

To meet the requirements set forth by NCC, Clinical Sites and OSHA, you will need to obtain and upload to myRecordTracker® documentation for the following immunizations and tests before beginning your experience at Clinical Sites.

## IMMUNIZATIONS (Vaccinations)

**All students** are required to UPLOAD **immunization records** to myRecordTracker® for the following:

- **Varicella** (Chickenpox) – 2 doses after age 12 months
- **MMR*** – 1st dose after age 12 months, and 2nd dose after age 4 years
- **Hepatitis B** – 3 doses
- **TDAP** – Tetanus Diphtheria Acellular Pertussis *(Dated within 10 years)*
- **Influenza** – Current Season *(Required if participating September – April)*

## HEPATITIS B SURFACE ANTIBODY, QUANTITATIVE TITER

- **All Students** are required to obtain the **Hepatitis B Surface Antibody, QUANTITATIVE Titer** to determine immunity status and UPLOAD the **lab report** to myRecordTracker®**.**
- **Titer results must be dated within the past three years.**

## HEPATITIS B REPEAT SERIES OR BOOSTER *(Required if titer shows no or low immunity)*

- If the Hepatitis B Surface Antibody, Quantitative Titer shows no immunity, the repeat series of three doses should be started immediately.
- If the titer shows low immunity, a booster dose should be given immediately. The repeat titer should be given one month after the booster or last dose.
- Any repeat doses, booster, and titer reports must be uploaded to myRecordTracker® each time they are received.

## COVID-19 VACCINATION AND BOOSTER RECORDS

- COVID-19 Vaccinations are required by major healthcare networks to protect yourself and others while working in healthcare. Please upload proof of your vaccination(s). You must provide proof of two doses of monovalent vaccines (Pfizer or Moderna) received prior to September 1, 2022, or one dose of bivalent vaccine if vaccinated after that date. If you received only one dose of monovalent vaccine (one dose of J & J, or one dose of the Pfizer or Moderna vaccine), you are required to also receive one dose of the bivalent Moderna or Pfizer vaccine. You will be required to provide a copy of your COVID-19 vaccination card to your internship/externship/clinical site.
- If you have received a COVID-19 booster, please provide proof, although not mandatory at this time.

## TITERS (Bloodwork)

- **If immunization records are not available,** students are required to obtain titers to determine immunity status for the above listed requirements. **All titer results must be dated within three years.**
- Documentation of the Chickenpox disease is not considered acceptable for immunity, and a titer must be drawn.

## SUPPORTING DOCUMENTATION OPTIONS

- Immunization records can include your childhood and/or school immunization records – or a printout from your medical provider.
- Lab reports must contain titer results **dated within the past three years** showing level of immunity.

**Name**:_____ **Student ID #**_____

*Last* *First* *Middle*

# TUBERCULOSIS SCREENING REQUIREMENTS

In order for any student to observe in any area of the Clinical Site, Tuberculosis screening must be administered and documented and may be obtained by skin testing or blood test. **Two** TB skin tests are required **within 12 months, the most recent within 3 months, of the start of your Clinical Experience**. A QuantiFERON-TB Gold blood test may be administered **within 3 months of the start of your Clinical Experience,** in lieu of the two TB skin tests. **Document the results below and/or upload relevant documentation.**

***** If results are positive (greater than 10mm induration), or if there is any history of a previous positive TB test, either the QuantiFERON-TB Gold blood test or chest x-ray must be performed.***

A. **Two TB Skin Tests** - within 12 months, **the most recent within 3 months**, of the start of the clinical experience.

| STEP 1 | Date | Arm | Results (mm) | Signature |
|---|---|---|---|---|
| Administered | | | | |
| Results Read | | | ☐ (+) ☐ (-) ____mm | |

***** AND *****

| STEP 2 | Date | Arm | Results (mm) | Signature |
|---|---|---|---|---|
| Administered | | | | |
| Results Read | | | ☐ (+) ☐ (-) ____mm | |

***OR -***

B. **QuantiFERON-TB Gold or T-SPOT-*TB* blood test** - within **3 months** of the start of the clinical experience:
**MUST UPLOAD COPY OF LAB REPORT.**

***OR -***

C. **Chest X-Ray** - within **6 months** of the start of the clinical experience:
**MUST UPLOAD COPY OF CHEST X-RAY REPORT.**

***NOTE:*** *TB testing can be administered at the location of the student's choice (i.e., private physician's office, NCC Health and Wellness Center, or at any clinic.) The student is responsible for any and all charges.*

## TO BE COMPLETED BY MEDICAL PROVIDER WHEN TB RESULTS ARE VERIFIED:

***Please print, type or stamp:***

Name of Licensed Provider_____

Address:_____

Signature of Licensed Provider_____ Date_____