Pueblo Community College: Health Professions Division Health Certification

Legal Name:	Student ID:	Birthdate:	Phone:
Address:	City/State:	Zip:	Cell:

Instructions: Complete the immunization and signature sections on this form as well as the Essential Functions page specific to your program. All information/test results must be complete before you submit this form. Questions may be directed to the PCC Health Clinic @ (719) 549-3315. You MUST make a copy of your completed health form and retain it. You may need to provide it to a clinical agency. *DO NOT RETURN THIS FORM TO THE CLINICAL COORDINATOR UNTIL ALL RESULTS AND SIGNATURES ARE COMPLETE.*

DATE	TYPE OF TEST/VACCINE	RESULTS	AUTHORIZED SIGNATURE / MEDICAL TITLE
#1_____ #2_____ ***OR*** *QFT*_____ *CXR* _____	**PPD/TB (**Tuberculin Skin Test): You are required to show proof of 2 consecutive, annual TB skin tests(one in the last 12 months). If you've never had a TB skin test or haven't had one within the last 2 years, you must complete a two- step TB Skin Test **OR** Quantiferon TB Gold (QFT-G) blood test. **Chest X-Ray:** If you have a positive PPD or QFT-G blood test, a Chest X-ray report must be submitted.	#1_____ #2_____ *QFT*_____ CXR_____	_____ _____ _____ _____
_____	**Tetanus**: Must provide proof of (1) Tdap vaccination in lifetime and Td booster within 10 years of program entry; Tdap may substitute for Td (Dtap will not be accepted)		_____
#1_____ #2_____ T_____ B_____	**MMR #1** **MMR # 2** Proof of (2) MMR (Measles,Mumps,Rubella) vaccinations in lifetime **OR** laboratory evidence of immunity with MMR Titer **MMR Titer** **MMR Booster** *(MMR vaccine booster given if titer results are negative and/or equivocal)*	T _____	_____ _____ _____ _____
#1_____ #2_____ #3_____	**Hepatitis B**: Proof of 3-dose Hepatitis B series in lifetime ***OR*** laboratory evidence of immunity with Hepatitis B Titer. (*Hepatitis B Waiver form may be signed)*		_____ _____ _____
_____	**Influenza vaccination*:*** Required annually for all hospital based clinicals. May also be required for other clinical sites (please check with your instructor). **(If allergic, you must provide physician explanation. If allergic or refuse influenza vaccination, you will be required to wear a mask, at all times, during clinical studies)**	_____	_____
T_____ T_____	***The following lab tests may be required by clinical sites*: *(Please check with your instructor)*** **Hepatitis B Titer** **Varicella Titer (Required for Respiratory Care Program)**	T_____ T_____	_____ _____

I give permission to release information on this health form to the professional college and clinical affiliate staff if it's deemed necessary for the benefit and/or safety of myself and others.

Signature of Immunization Recipient _____ ***Date:***_____

Date Due_____ ***Program Name***_____ ***Semester Start***_____

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