# 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_________<br>#2_________<br>*OR*<br>*QFT*_________<br>*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.<br>**Chest X-Ray:** If you have a positive PPD or QFT-G blood test, a Chest X-ray report must be submitted. | #1_________<br>#2_________<br>*QFT*_________<br>CXR_________ | ______________________<br>______________________<br>______________________<br>______________________ |
| _________ | **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) | Tdap or Td<br>**(Please Circle)** | ______________________ |
| #1_________<br>#2_________<br>T_________<br>B_________ | **MMR (Measles,Mumps,Rubella):** Proof of (2) MMR vaccinations in lifetime **OR** laboratory evidence of immunity with MMR Titer<br>**MMR Titer**<br>**MMR Booster** *(MMR vaccine booster given if titer results are negative and/or equivocal)* | T _________ | ______________________<br>______________________<br>______________________<br>______________________ |
| #1_________<br>#2_________<br>#3_________<br>T_________ | **Hepatitis B**: Proof of (3) dose Hepatitis B series in lifetime ***OR*** laboratory evidence of immunity with Hepatitis B Titer. Hepatitis B Titer may also be required by clinic site even if series has been completed. (Please check with instructor on program requirements)<br>*(Hepatitis B Waiver form may be signed if program allows)* | T_________ | ______________________<br>______________________<br>______________________<br>______________________ |
| #1________<br>#2________<br>T_________ | **Varicella:** Proof of (2) Varivax vaccinations in lifetime **OR** laboratory evidence of immunity with Varicella Titer<br>**Varicella Titer** | T_________ | ______________________<br>______________________<br>______________________ |
| _________<br>_________ | **Influenza*:*** Required annually for all hospital based clinicals.<br>(If allergic or refuse influenza vaccination, you will be required to wear a mask, at all times, during clinical studies. Physician explanation will be required for those allergic to vaccination) | _________<br>_________ | ______________________<br>______________________ |

**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***_________________ Rev: 1-2016