# IMMUNIZATION REQUIREMENTS

## Practical Nursing Certificate Students

**Name**

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

**Address**

<table>
<thead>
<tr>
<th>Street</th>
<th>Apt.</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

**Telephone**

| Area Code | ______________________ |

**Semester entering:** Fall 20 ___  Spring 20 ___

**Have you previously attended GCC?** No ___  Yes ___  If yes, when ______________________

**Have you previously applied to any GCC Health Occupation Programs?** No ___  Yes ___

**Which one?**

- [ ] ADN
- [ ] PNC
- [ ] PMC

**When**________________________

**Previous Name(s)**

| ______________________ | __________ | 

**Today’s Date**

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All Practical Nursing Certificate (PNC) students must provide appropriate documentation of immunity as required by the Massachusetts Department of Public Health, Greenfield Community College and clinical sites, regardless of age or number of credits. Students must also provide documentation of medical clearance to participate in the PNC program on the Physical Examination form provided after acceptance.

Students are responsible for providing the Health Records Office with complete Immunization requirement documentation (pages 1&2) before submitting the PNC Program application to the Office of Admission. History and Physical Exam forms are due by May 30th, after acceptance to the program. Only GCC PNC HX & PE forms are acceptable. These forms (pages 1-4) must have been completed no sooner than September 1st, and submitted by May 30th, to qualify as within a year of program entry.

Tuberculin Skin Test results must be obtained and are due between June 15th and August 1st (see Tuberculin Skin Test form, page 5, for specific requirements). Chest X-ray results are required for positive Tuberculin Skin test.

Return completed health forms to: Greenfield Community College Health Records Office, Main Campus or mail to GCC Health Records, One College Drive, Greenfield MA 01301. Please call the Health Records Office, (413) 775-1431 to check that forms have been received and that information is complete. If you have any questions concerning the health requirements for the PNC Program, please call the Health Records Office.

Prior to application, students are responsible for checking with the Health Records Office for any recent changes in health requirements for this program.

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Revised Sep 2012
**IMMUNIZATION INFORMATION**

Student Name ____________________________________________ Date of birth ______ /______ /______

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
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</table>

Has primary DPT series been completed? ______  # DPT doses: _____  date series completed: ____ /____ /____

<table>
<thead>
<tr>
<th>Tetanus-Diphtheria-Pertussis (Tdap) (within the past 10 years)</th>
<th>____ /____ /____ Tdap</th>
</tr>
</thead>
<tbody>
<tr>
<td>*MMR vaccine #1</td>
<td>____ /____ /____ *must be on or after date of first birthday and must be after 1/1/68</td>
</tr>
<tr>
<td>**MMR vaccine #2 or serologic proof of immunity:</td>
<td>____ /____ /____ **must be at least 1 month after the first dose</td>
</tr>
<tr>
<td>Positive Measles Antibody (IgG)</td>
<td>____ /____ /____ → copy of lab report is required, please attach</td>
</tr>
<tr>
<td>Positive Mumps antibody (IgG)</td>
<td>____ /____ /____ → copy of lab report is required, please attach</td>
</tr>
<tr>
<td>Positive Rubella antibody (IgG)</td>
<td>____ /____ /____ → copy of lab report is required, please attach</td>
</tr>
<tr>
<td>Hepatitis B vaccine #1</td>
<td>____ /____ /____ dose #1</td>
</tr>
<tr>
<td>Hepatitis B vaccine #2</td>
<td>____ /____ /____ dose #2</td>
</tr>
<tr>
<td>Hepatitis B vaccine #3 **Or Quantitative Positive Hepatitis B surface antibody</td>
<td>____ /____ /____</td>
</tr>
<tr>
<td>Positive Varicella antibody</td>
<td>____ /____ /____ → copy of lab report is required, please attach</td>
</tr>
<tr>
<td><strong>Or</strong></td>
<td></td>
</tr>
<tr>
<td>Varicella vaccine #1</td>
<td>____ /____ /____</td>
</tr>
<tr>
<td>Varicella vaccine #2**</td>
<td>____ /____ /____ **must be at least 1 month after the first dose</td>
</tr>
</tbody>
</table>

**Signature of Health Care Provider or Designee is Required:**

Signature ________________________________ Date ________________________________

Printed Name ________________________________ Telephone ________________________________

Address ________________________________ Fax ________________________________

Revised Sep2012
HISTORY AND PHYSICAL EXAM REQUIREMENTS
Practical Nursing Certificate Students

HEALTH HISTORY

NAME________________________________________
DOB________________________________________

(To be filled out by the student)

COMPLETE AND BRING THIS HISTORY FORM WITH YOU TO YOUR PHYSICAL EXAM APPOINTMENT FOR REVIEW WITH THE EXAMINING HEALTH CARE PROVIDER

Please check if you have or have ever had any of the following:

- chicken pox
- frequent/severe headaches
- seizure disorder/epilepsy
- dizziness
- repeated fainting
- problems with vision
- problems with hearing
- asthma
- frequent cough
- exposure to tuberculosis/positive TB test
- shortness of breath/difficulty breathing
- chest pain with activity
- heart disease/condition/murmur
- high blood pressure
- frequent diarrhea
- frequent/severe belly pain
- cancer
- hernia/rupture
- kidney/bladder problems
- unexplained weight loss/gain
- swollen glands for longer than 2 weeks
- skin disease/disorder
- back injury or problems
- numbness or decreased feeling in hands, feet
- varicose veins
- diabetes or high blood sugar
- anxiety/depression
- mental illness
- drug/alcohol dependency
- hospitalization
- surgery
- latex allergy
- other

limited or painful movement or use of:

- neck
- shoulder(s)
- elbow(s)
- wrist(s)
- hand(s)
- hip(s)
- knee(s)
- ankle(s)
- feet
- back

Please explain any items checked. Include approximate dates:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Please list all medications that you currently take:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Please list all allergies (food, medication, latex, environmental) & reaction:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
Have your activities been restricted during the past 5 years?

yes ☐ no ☐ If yes, please explain: ________________________________________________

____________________________________

Do you have any condition which might require adaptation of your educational/clinical program?

yes ☐ no ☐ If yes, please describe: ________________________________________________

____________________________________

STUDENT STATEMENT

♦ The health history information given is correct to the best of my knowledge.
♦ I agree to notify Health Records Office regarding any significant change in health status.
♦ I understand that all health information received by the Health Records Office is confidential and will not be released by the Health Records Office without my signed consent.
♦ I understand that failure to provide complete health requirements by the deadlines will result in the inability to attend classes. I understand that it is my responsibility to provide all the required documentation and to verify the receipt by the Health Records Office of complete documentation.

____________________________________

Student’s Signature

____________________________________

Date

RELEASE of INFORMATION

I, ____________________________, give Greenfield Community College Health Records permission to release information regarding immunizations, immunity to infectious diseases, results of Tuberculosis screening and treatment, and history of allergies, including latex allergy, to the PNC program coordinator and clinical agencies (e.g. hospitals, long-term care facilities, health centers) for my clinical placements.

____________________________________

Student’s Signature

____________________________________

Date

I give Health Records permission to release relevant medical history on a need-to-know basis to the PNC Coordinator if necessary to determine ability to safely participate in the PNC program.

____________________________________

Student’s Signature

____________________________________

Date

BRING THIS HISTORY FORM WITH YOU TO REVIEW WITH THE HEALTH CARE PROVIDER WHO PERFORMS YOUR PHYSICAL EXAM
PHYSICAL EXAMINATION

(BRING THIS FORM TO YOUR PHYSICAL EXAM between September 1 and May 30.)
To be completed and signed by a physician, nurse practitioner or physician’s assistant

A. To the Examining Health Care Provider:

1. Successful completion of the Practical Nursing Certificate Program requires proficiency in the performance of a variety of skills. Technical standards, meant to clarify minimal standards for essential affective and psychomotor functions, require students to:
   1) be ambulatory    2) be able to lift a minimum of 50 lbs    3) possess fine motor coordination required to perform such technical skills such as preparation and administration of medications    4) have visual acuity to perform technical skills such as physical assessment, preparation of proper dosage of medications    5) have auditory perception allowing effective use of stethoscope and communication    6) have emotional stability required to exercise sound judgment and intervention activities    7) have emotional maturity to develop appropriate therapeutic relationships

2. PLEASE REVIEW STUDENT HISTORY (SECTION II) for completeness and provide any additional history here: (This information is strictly for use by the Student Health Records Office and will not be released without the student’s written consent.)

_________________________________________________________

B. Physical Examination

Date of Physical Examination ______/_____/______

Please complete the physical exam form provided, including a summary of active medical problems and recommendations.

Student Name ___________________________________________ DOB __/_____/______ Age ________________

Height __________ Weight __________ BP __________ / __________ Pulse __________

Vision: Corrected R __________ L __________ Uncorrected R __________ L __________

Hearing: Spoken word __________ Whispered word __________ Tuning fork __________ Audiometry __________

(if available)

<table>
<thead>
<tr>
<th>skin/scars</th>
<th>normal</th>
<th>abnormal</th>
<th>musculoskeletal:</th>
<th>normal</th>
<th>abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEENT</td>
<td></td>
<td></td>
<td>hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>neck</td>
<td></td>
<td></td>
<td>wrists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>lymph nodes</td>
<td></td>
<td></td>
<td>elbows</td>
<td></td>
<td></td>
</tr>
<tr>
<td>thorax and lungs</td>
<td></td>
<td></td>
<td>shoulders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>heart</td>
<td></td>
<td></td>
<td>spine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>abdomen</td>
<td></td>
<td></td>
<td>hips</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hernia</td>
<td></td>
<td></td>
<td>knees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>peripheral vascular</td>
<td></td>
<td></td>
<td>ankles</td>
<td></td>
<td></td>
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<tr>
<td>neurological</td>
<td></td>
<td></td>
<td>feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>mental status</td>
<td></td>
<td></td>
<td>other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please describe and comment on any abnormal findings:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Revised Sep2012
C. Summary of Medical/Behavioral Problems and Recommendations:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

D. Is this applicant capable of full participation in the PNC Program as described by the technical standards in SECTION V, Part A?

yes _____  no  ______

Please describe any accommodations needed to meet the technical standards required for participation in the PNC Program:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Are there any further evaluations which should be performed prior to this applicant’s participation?

yes _____  no  ______

If yes, please explain and give dates for scheduled evaluations:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Results of additional evaluation(s):

_____ enclosed

_____ to be sent to: Greenfield Community College Health Records
One College Drive
Greenfield MA 01301

E. Signature Required

________________________________________________________________________   /   /   
Signature                                          Date

   /   /   
Date of exam
(must be within one year of start date and updated if any significant change in health since exam)

Name of examining MD, NP or PA (please print)

Address: __________________________________________

________________________________________________________________________

Telephone: __________________________________________

FAX: __________________________________________
Clinical placement sites for the Practical Nursing Certificate Program require Tuberculosis Testing.

An intradermal tuberculosis skin test (Mantoux or PPD) done within 3 months of starting the program. This test should not be done earlier than June 15 or later than July 29, with reading and submission deadline August 1.

A Tine test is not acceptable.

A positive PPD requires a chest x-ray.

**PPD**
Between June 15 and August 1

Date planted: ______ / _____ / ______

Date read: ______ / _____ / ______

Result: _____ mm induration

*Please do not report as negative or positive*

**CHEST X-RAY**
- **New positive** PPD requires a current chest x-ray.
- **Previous positive** PPD requires a chest x-ray.

X-ray date: _____ / _____ / _____ Results: ________________ Copy of x-ray report is required

___ Report attached

___ Report to be sent

additional information: ________________________________

**Signature of Health Care Provider or Designee is Required**

Signature: ________________________________ Date: ________________________________

Printed Name: ________________________________ Telephone: (______) _____-___________

Address: ________________________________ Fax: ________________________________