



GREENFIELD COMMUNITY COLLEGE

Health Services

One College Drive, Greenfield, Massachusetts 01301

TEL: (413) 775-1430 FAX: 775-1434



IMMUNIZATION REQUIREMENTS
Practical Nursing Certificate Students

Name (Last, First, Middle, Date of Birth), Address (Street, Apt., City, State, Zip Code, Student Number or Social Security Number), Telephone (Area Code), Semester entering: Fall 20, Spring 20, Have you previously attended GCC? No, Yes, If yes, when, Previous Name(s)

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 Service Office with complete Immunization requirement documentation 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. These forms 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 May 15th and August 15th (see Tuberculin Skin Test form for specific requirements). Chest X-ray results are required for positive Tuberculin Skin test.

Return completed health forms to: Greenfield Community College Health Services Office, North Module, Main Campus or mail to GCC Health Services, One College Drive, Greenfield MA 01301. Please call the Health Service Office, (413) 775-1430 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 Services Office.

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

Office use only:
__ IZ
__ PPD
__ HX
__ PE
__ PC CONSULT
__ ROI

IMMUNIZATION INFORMATION

Student Name _____
Last First Middle

Date of birth ____ / ____ / ____
month day year

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

Physician diagnosis or history of disease is not acceptable.	Tetanus-Diphtheria-Pertussis (Tdap) (if last Tetanus Diphtheria (Td) is > 2 years old)	____ / ____ / ____ Tdap ____ / ____ / ____ Td
	*MMR vaccine #1	____ / ____ / ____ <i>*must be on or after date of first birthday and must be after 1/1/68</i>
	MMR vaccine #2 or serologic proof of immunity:	____ / ____ / ____ <i>must be at least 1 month after the first dose</i>
	Positive Measles Antibody (IgG)	____ / ____ / ____ → copy of lab report is required, please attach
	Positive Mumps antibody (IgG)	____ / ____ / ____ → copy of lab report is required, please attach
	Positive Rubella antibody (IgG)	____ / ____ / ____ → copy of lab report is required, please attach
	Hepatitis B vaccine #1	____ / ____ / ____ dose #1
	Hepatitis B vaccine #2	____ / ____ / ____ dose #2
	Hepatitis B vaccine #3 or Positive Hepatitis B surface antibody	____ / ____ / ____ dose #3 ____ / ____ / ____ → copy of lab report is required, please attach
	Positive Varicella antibody or Varicella vaccine #1	____ / ____ / ____ → copy of lab report is required, please attach If blood test is negative, two doses of vaccine are required to provide immunity ____ / ____ / ____
Varicella vaccine #2**	____ / ____ / ____ <i>**must be at least 1 month after the first dose</i>	

Signature of Health Care Provider or Designee is Required:

Signature _____ Date _____

Printed Name _____ Telephone _____

Address _____ Fax _____



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**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:

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

limited or painful movement or use of:

- | | | | | |
|---------------------------------|--------------------------------------|-----------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> neck | <input type="checkbox"/> shoulder(s) | <input type="checkbox"/> elbow(s) | <input type="checkbox"/> wrist(s) | <input type="checkbox"/> hand(s) |
| <input type="checkbox"/> hip(s) | <input type="checkbox"/> knee(s) | <input type="checkbox"/> ankle(s) | <input type="checkbox"/> feet | <input type="checkbox"/> 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): _____

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

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 Services Office regarding any significant change in health status.
- ◆ I understand that all health information received by the Health Services Office is confidential and will not be released by the Health Services 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 Services Office of complete documentation.

Student's Signature

Date

RELEASE of INFORMATION

I, _____, give Greenfield Community College Health
Please print name
Services 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 Services 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

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 Service 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)

	normal	abnormal
skin/scars		
HEENT		
neck		
lymph nodes		
thorax and lungs		
heart		
abdomen		
hernia		
peripheral vascular		
neurological		
mental status		

	normal	abnormal
musculoskeletal:		
hands		
wrists		
elbows		
shoulders		
spine		
hips		
knees		
ankles		
feet		
other:		

Please describe and comment on any abnormal findings:

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 Services
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: _____

Tuberculin Skin Test (PPD/Mantoux form)

student name: _____	date of birth: _____
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Clinical placement sites for the Practical Nursing Certificate Program require Tuberculosis Testing.

An intradermal tuberculosis skin test (Mantoux or PPD) done within 3 ½ months of starting the program. This test should not be done earlier than May 15 or later than August 15.

A Tine test is not acceptable.

A positive PPD requires a chest x-ray.

<p>PPD Between June 1 and July 15</p> <p>Date planted: ____/____/____ Date read: ____/____/____ Result: ____ mm induration <i>Please do not report as negative or positive</i></p>

<p>CHEST X-RAY</p> <ul style="list-style-type: none"> ◆ New positive PPD requires a current chest x-ray. ◆ Previous positive PPD requires a chest x-ray. <p>X-ray date: ____/____/____ Results: _____ Copy of x-ray report is required</p> <p>___ Report attached ___ Report to be sent</p> <p>additional information: _____</p>
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Signature of Health Care Provider or Designee is Required

Signature: _____	Date: _____
Printed Name: _____	Telephone: (____) _____ - _____
Address: _____ _____	Fax: _____