



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 _____ | | | _____ |
| _____ | _____ | _____ | Date of Birth |
| Last | First | Middle | |
| Address _____ | | | _____ |
| _____ | _____ | _____ | Student Number or Social Security Number |
| Street | Apt. | | |
| _____ | | | |
| _____ | _____ | _____ | |
| City | State | Zip Code | |
| 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.

IMMUNIZATION INFORMATION

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

Student Name _____

Date of birth ____/____/____

Last

First

Middle

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 **MMR vaccine #2 or serologic proof of immunity: | ____/____/____ *must be on or after date of first birthday and must be after 1/1/68 ____/____/____ **must be at least 1 month after the first dose |
| | Positive Measles Antibody (IgG) | ____/____/____ <input type="checkbox"/> copy of lab report is required, please attach |
| | Positive Mumps antibody (IgG) | ____/____/____ <input type="checkbox"/> copy of lab report is required, please attach |
| | Positive Rubella antibody (IgG) | ____/____/____ <input type="checkbox"/> copy of lab report is required, please attach |
| | Hepatitis B vaccine #1 Hepatitis B vaccine #2 Hepatitis B vaccine #3 or Positive Hepatitis B surface antibody | ____/____/____ dose #1 ____/____/____ dose #2 ____/____/____ dose #3 ____/____/____ <input type="checkbox"/> copy of lab report is required, please attach |
| | Positive Varicella antibody or Varicella vaccine #1 Varicella vaccine #2** | ____/____/____ <input type="checkbox"/> copy of lab report is required, please attach If blood test is negative, two doses of vaccine are required to provide immunity ____/____/____ ____/____/____ **must be at least 1 month after the first dose |

Signature of Health Care Provider or Designee is Required:

Signature _____ Date _____

Printed Name _____ Telephone _____

Address _____ Fax _____