MARICOPA COMMUNITY COLLEGES

Allied Health STUDENT HEALTH AND SAFETY DOCUMENTATION CHECKLIST

Name:_____Student ID:_____Date:_____

Cell Phone:_____Home Phone _____Email:_____

Must attach documentation (copies of lab reports, immunization records, CPR card, etc.) as indicated for each of the following to be in compliance with Maricopa Community College requirements. Fingerprint clearance card, CPR certification and TB skin test must be current through the semester of enrollment or duration of practicum experiences. See "Explanation of Requirements" in the Allied Health Shared Student Policies handbook for specific detail.

A. MMR (Measles/Rubella, Mumps and Rubella): Requires documented proof of a positive IgG MMR titer or documented proof of One MMR series.

1. MMR vaccination: Dates: #1_____ #2_____
   OR

2. Date & titer results:

   Booster: _____
   Measles: _____ _____
   Mumps: _____ _____
   Rubella: _____ _____

B. Varicella (Chickenpox): Requires documented proof of positive IgG titer or documented proof of Varicella series.

1. Varicella vaccination dates: #1_____ #2_____ **OR**
2. Date & results of varicella IgG titer: Date: _____ Result: _____,
   Booster: _____

C. Tetanus/Diphtheria/Pertussis (Tdap): You must provide proof of a one-time Tdap vaccination and Td booster if 10 years or more since Tdap vaccination

1. Tdap vaccine: Date: _____
   OR
2. Td booster: Date: _____

D. Tuberculosis: Documentation is required for all tests. For individuals who have not received a TB test within the past year, will need to receive a 2-Step TB test. This consists of two separate TB test; an initial TB skin test and a second TB skin test 1-3 weeks apart. After completion of the 2-step, an annual update of TB skin test is sufficient. If you have a positive skin test, provide documentation of a QuantiFERON test or negative chest X-ray and annual documentation of a TB disease-free status. Most recent skin testing or blood test must have been completed within the previous six (6) months.

1. Negative 2-step TB Skin Test (TBST), including date of administration, date read, result, and name and signature of healthcare provider.

Initial Test (#1) Date: _____ Date Read: _____ Results: Negative or Positive
Boosted Test (#2) Date: _____ Date Read: _____ Results: Negative or Positive

2. Annual 1-step TBST (accepted only from continuing students who have submitted initial 2-step TBST)
Date: _____ Date Read: _____ Results: Negative or Positive

OR

3. Negative blood test (Either QuantiFERON or TSpot)

QuantiFERON Date: _____

T-Spot Date:_____

OR

4. Negative chest X-ray

OR

5. Documentation of a negative chest X-ray (x-ray report) or negative QuantiFERON result and completed Tuberculosis Screening Questionnaire (available in (American DataBank).

Date: _____

E. Hepatitis B: Documented evidence of completed series or positive antibody titer or signed declination form. If you have not received any injections, do not get a titer. The second injection of the series is 1 to 2 months after the first dose and the third injection is 4 to 6 months after the first dose.

Date Titer received:_____Results:_____

Date of 1st injection:_____Date of 2nd injection:_____Date of 3rd injection:_____

OR

HBV Vaccination Declination Attached

F. Influenza: Documented evidence of influenza vaccination for the current flu season or declination.

Date of Injection: _____ OR Signed Declination Form Attached

G. For Dental programs- Documented evidence of completed Ophthalmic Exam

Date of Exam: _____

H. For Dental programs- Documented evidence of completed Dental Exam (Excluding Mesa Community College)

Date of Exam: _____

I. For Dental programs-Documented evidence of completed Physical Exam

Date of Exam: _____

J. CPR Card (Healthcare Provider level): An official certification is required
(In-Person or Hybrid training courses are only accepted)

Date card issued:_____Expiration Date:_____

K. Level One Fingerprint Clearance Card: Date card issued:_____Expiration Date: _____

L. American DataBank Clearance Document: Passed Date:_____

M. Clearance for Participation in Clinical Practice

It is essential that allied health students be able to perform a number of physical activities in the clinical portion of their programs. At a minimum, students will be required to lift patients and/or equipment, stand for several hours at a time and perform bending activities. Students who have a chronic illness or condition must be maintained on current treatment and be able to implement their assigned responsibilities. The clinical allied health experience also places students under considerable mental and emotional stress as they undertake responsibilities and duties impacting patients' lives. Students must be able to demonstrate rational and appropriate behavior under stressful conditions. This declaration should not impede students with disabilities from applying or being accepted into the program.

I believe the applicant (print name) _____Date:_____

_____ WILL OR _____ WILL NOT be able to function as an allied Health student as described above.

If not, explained:

_____

_____

_____

Health Care Provider Form: Reviewed and signed by a licensed health care provider (M.D., D.O., nurse practitioner, or physician's assistant) within the past six (6) months of the start date.

Licensed Healthcare Examiner (M.D., D.O., N.P., P.A.):

Print Name: _____ Title: _____

Signature: _____ Date: _____

Address:

_____

City: _____ State: _____ Zip Code: _____