Health and Safety Requirements Worksheet

Name: _____ **Date**:_____

Use this worksheet ONLY as a guide to ensure that you have documentation of each requirement. Supporting documents (lab results, immunization records, signed healthcare provider form, etc.) for each requirement MUST be included. **THIS FORM DOES NOT CONSTITUTE PROOF.**

☐ **MMR (Measles/Rubeola, Mumps and Rubella)** To meet requirement:

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

OR

2. Date & positive IgG titer results:

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

☐ **Varicella (Chickenpox)** To meet requirement: History of disease is not sufficient.

1. Varicella vaccination dates: #1_____ #2_____

OR

2. Date & positive results of varicella **IgG** titer: Date: _____ Result: _____

☐ **Tetanus/Diphtheria/Pertussis (Tdap)** To meet requirement you must provide proof of a one-time Tdap vaccination and Td booster if 10 years or more since Tdap vaccination

Tdap vaccine: Date: _____
Td booster: Date: _____

☐ **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.

To meet requirement:

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

Date: _____

Health and Safety Requirements Worksheet (con't)

Name: _____ **Date**:_____

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☐ **Hepatitis B** To meet requirement:

1. Positive HbsAb titer Date: _____ Result: _____

   OR

1. Proof of 3 Hepatitis B vaccinations

   Hepatitis B vaccine/dates: #1_____ #2_____ #3_____

   OR

2. Hepatitis B declination- students who choose to decline Hepatitis B vaccine series must submit a HBV Vaccination Declination form.

☐ **Flu Vaccine** To meet requirement:

Documentation of current seasonal flu vaccine Date: _____

☐ **CPR (Healthcare Provider/BSL level or Equivalent) Certification** To meet requirement:

CPR card or certificate showing date card issued: _____ Expiration date: _____

☐ **Level One Fingerprint Clearance Card (FCC)** To meet requirement:

Level One FCC including date card issued: _____ Expiration date: _____

☐ **Health Care Provider Signature Form** To meet requirement:

Healthcare Provider Signature Form signed and dated by healthcare provider. Date of exam: _____

Allied Health Student Health and Safety Documentation Checklist

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.

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, explain: _____

_____

_____

Licensed Healthcare Provider (MD, DO, NP, or PA) Verification of Health and Safety

Print Name:_____Title: _____

Signature:_____Date: _____

Address: _____

City:_____State: _____

Telephone: _____

MARICOPA COMMUNITY COLLEGE DISTRICT
ALLIED HEALTH PROGRAMS

VACCINATION DECLINATION

(PRINT) Student Name_____ Date_____

Hepatitis B Vaccination Declination

I understand that due to my exposure to blood or other potential infectious materials during the clinical portion of my allied program, I may be at risk of acquiring Hepatitis B virus (HBV) infection. The health requirements for the allied health program in which I am enrolled, as described in the Student Handbook, include the Hepatitis B vaccination series as part of the program's requirements. I have been encouraged by the faculty to be vaccinated with Hepatitis B vaccine; however, I decline the Hepatitis B Vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. By signing this form, I agree to assume the risk of a potential exposure to Hepatitis B virus and hold the Maricopa Community College Allied Health Program as well as all health care facilities I attend as part of my clinical experiences harmless from liability in the event I contract the Hepatitis B virus.

_____ _____

Student Signature Date