A. MMR (Measles/Rubeola, Mumps, Rubella): Requires documented proof of two MMRs in lifetime or a positive titer for each of these diseases.

1st MMR Date: _______________ 2nd MMR Date: _______________
OR
Date and results of titer: Measles/Rubeola ___________ Mumps ___________ Rubella ___________

B. Varicella (Chickenpox): Requires documented proof of two (2) vaccinations or positive IgG titer.

1st Varicella Date: ______________ 2nd Varicella Date: ______________
OR
Date & results of IgG titer:___________________________________________

C. Tetanus/Diphtheria (Td) immunization within the past 10 years. Td Date: ____________________

D. Tuberculosis:
Two-Step Testing** for initial skin testing of adults who will be retested periodically

TWO-STEP TESTING
Use two-step testing for initial skin testing of adults who will be retested periodically.
If first test positive, consider the person infected.
If first test negative, give second test 1-3 weeks later.
If second test positive, consider person infected.
If second test negative, consider person uninfected.
If both parts of Two step test are negative then subsequent testing is done annually with one step procedure

INITIAL TEST:
Test Given Date Read Result

SECOND TEST (1-3 weeks after initial test):
Test Given Date Read Result

OR Annual TB skin test (PPD):
Test Given Date Read Result
If annual, provide proof of negative TB skin test from previous year:
Test Given Date Read Result

OR Previous Positive PPD test:
Provide documentation of negative chest x-ray/evidence of TB disease free status Date of chest x-ray Result

*If applicant has ever had a positive reaction, the test is not to be repeated. Other evidence that the applicant is free from Tuberculosis will be required. **Core Curriculum on Tuberculosis What the Clinician Should Know, Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Division of Tuberculosis Elimination, Atlanta, Georgia, 4th Edition, 2000.

(continued)

***Please attach documentation (test results, medical records, etc.) as proof for all immunizations to this Health Documentation Form***
E. Hepatitis B: Documented evidence of completed series or positive antibody titer or declination. If beginning series, first injection must be according to your Program’s required timeline and the series must be completed within 6 months.

Date of 1st injection: ___________  Date of 2nd injection: ___________  Date of 3rd injection: ___________

OR

Hep B Titer Date: _________________  Titer Results: _____________________________

OR

Signed Declination Form attached

F. Influenza: Documented evidence of influenza vaccination within the past year or declination.

Date of injection: ______________________________

OR

Signed Declination Form attached

G. 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 __________ 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:  _________________________________________

***Please attach documentation (test results, medical records, etc.) as proof for all immunizations to this Health Documentation Form***

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