This form must be submitted with your health documentation.

<table>
<thead>
<tr>
<th>Material Required</th>
<th>Description</th>
<th>Student Initial</th>
<th>Office Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part I: Background Check and Drug Screen</strong></td>
<td>A background check and drug screen will be completed annually through ESS. The due date will be provided at orientation, and a personalized link will be emailed to your calhoun.edu address from es2.com (Employment Screening Services).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Part II: Physical and Eligibility Criteria Forms</strong></td>
<td>This form requires a healthcare provider’s signature and is valid for 3 years. The forms are included in this packet and can be found in your Blackboard Toolkit for Success course.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Part III: Proof of Vaccination/Immunization Form</strong></td>
<td>A 2-step TB skin test, T-spot, or Quantiferon test from the current year is required. We will also accept a chest x-ray from this year, or 3 consecutive years of negative TB skin tests, including the one from current calendar year. After the initial results are submitted, we will require updated results every 12 months from your test date. In the case of chest x-rays, we require updates after 2 years.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Part IV: Identification and certification cards</strong></td>
<td>Copies of your insurance cards, a letter from your insurance provider, or a signed waiver is required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Student Acknowledgment</strong></td>
<td>For the purpose of determining eligibility for my educational experiences, I hereby give my permission for the Division of Health to contact the Provider who completed this health form for further information if needed. I understand that this form and immunization records may be duplicated for a clinical agency upon request. NOTE: Additional medical examinations and a specific release from a physician may be required any time (for example, during pregnancy, infectious disease, interference with mobility, emotional instability, etc.) if it is deemed necessary for the faculty to evaluate your state of health.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Medical Insurance Cards / Waiver | | |
| CPR Certification | Your Basic Life Support CPR certification must be issued by one of the following providers and valid for a minimum of 12 months: |
| | o American Heart Association BLS for Healthcare Providers |
| | o American Red Cross BLS Healthcare Provider, or |
| | o ASHI BLS for Healthcare Providers and First Responders. |
| Valid Photo ID | This may be a driver’s license, passport, or military ID. | | |

____________________________________________________________
Student’s Signature
Date
# Explanation of Health Information Requirements

<table>
<thead>
<tr>
<th>Item</th>
<th>Documentation Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Questionnaire (Physical Examination)</td>
<td><em>(Part II) Health Questionnaire</em> form must be completed and signed by a <strong>physician, physician’s assistant, or a nurse practitioner</strong>. Health Department stamps are <strong>not</strong> valid. You may see any MD, PA, or CRNP of your choosing to have this form completed. However, please make sure that all information requested is provided – including Provider’s Printed Information and Signature. <strong>Incomplete forms will not be accepted.</strong></td>
</tr>
<tr>
<td>Varicella (Chicken Pox)</td>
<td>A copy of your vaccination record should show two doses each of vaccination (MMR and Varicella). If you <strong>have had the disease</strong> – you must have a titer* drawn to prove immunity. Documentation is required – i.e. titer laboratory results or vaccination records from your doctor’s office. If titer results indicate that you are not immune, you must repeat the immunization. If you have never had the disease or vaccination – you will need to be vaccinated. <strong>Please note:</strong> If you require the MMR immunization, you should not be pregnant <strong>nor</strong> should you become pregnant for three months after receiving the vaccine.</td>
</tr>
<tr>
<td>Measles (Rubeola)</td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
</tr>
</tbody>
</table>
| Hepatitis B | The Hepatitis B immunization is a series of vaccinations that requires 6 months to complete. For instance:  
- You receive the first vaccination (begins on July 1)  
- You receive the second vaccination (due August 1)  
- You receive the third vaccination (due January 1)  
- A titer is drawn on or after January 15th to confirm immunity  
Documentation of your vaccinations, a positive titer is required before registering, or a signed waiver are required. If currently in the process of receiving the vaccinations, submit proof of your received vaccinations and a signed waiver. The additional vaccinations in the series may be submitted as they are received. |
| Tetanus (Tdap) | A Tetanus vaccination including Diphtheria and Pertussis is required within the past 10 years. |
| Tuberculosis: PPD (TB Skin Test), X-Ray, or Blood Test | A 2-step TB Skin test is required for all participants. A 2-step TB skin test takes a minimum of 10 days to complete. For instance:  
Day 1 (Monday): You receive a TB skin test (injection that is given just beneath the skin).  
Day 3 (Wednesday): You return to your health care provider to have the results documented.  
Day 8 (next Monday): You receive the second TB skin test.  
Day 10 (next Wednesday): You return to your health care provider to have the results documented.  
TB Skin tests are valid for 12 months.  
A Chest x-ray within the past year is required for any past positive TB skin test result and is valid for 2 years.  
Quantiferon or T-Spot Blood test for TB infection can be used in lieu of a 2-step test and is valid for 12 months.  
3 consecutive years of TB skin tests will also be used in lieu of a 2-step test and must include results from the current calendar year. |

*A titer is a blood test that determines immunity.*
### Division of Health

#### Health Questionnaire

**To the Student:**

- **Student Name (Last, First MI)**
- **Telephone** ( ) -
- **Student Number (C#)**

<table>
<thead>
<tr>
<th>Program</th>
<th>Dental Assistant</th>
<th>EMT Basic</th>
<th>Medical Lab Tech</th>
<th>Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Circle one)</td>
<td>Paramedic</td>
<td>Physical Therapist Assistant</td>
<td>Surgical Technology</td>
<td></td>
</tr>
</tbody>
</table>

**Allergies** (Food/Drug/Latex, etc)

**STUDENT AFFIRMATION:** I understand the student academic role and clinical performance requirements as noted on the essential functions form and agree that I have the primary responsibility of my own health status. I agree that I will not knowingly place myself or others in unsafe situations based upon my physical, mental, or emotional limitations. I have completed and signed the essential functions form and health questionnaire. I authorize my health care provider to release the information requested below concerning my health status to Calhoun Community College Division of Health Sciences. A student not being truthful or falsifying the health documents will be dismissed from Program.

**NOTE:** Additional medical examinations and a specific release from a physician may be required any time (for example, during pregnancy, infectious disease, interference with mobility, emotional instability, etc.) if it is deemed necessary for the faculty to evaluate your state of health.

---

**To the Physician:**

- **Height**
- **Weight**
- **BP** / 
- **Pulse**
- **Vision: 20/_____ OS**
- **20/_____ OD**
- **Vision Corrected?** Y N
- **Corrected by:** Glasses Contact lens
- **Color Blind?** Y N
- **Hearing Deficits?** Y N
- **Hearing Corrected?** Y N

**NORMAL** | **ABNORMAL FINDINGS**

| Cardiovascular | 
| Pulse | 
| Heart | 
| Lungs | 
| Skin | 
| E.N.T. | 
| Gastrointestinal | 
| Musculoskeletal | 
| Neurological | 
| Other | 

On the basis of the health examination on this day, the student meets the essential functions (Program Specific Essential Functions listed on next page) described herein for the educational program indicated above.

- Yes ☐
- No ☐
- Limited ☐

If limited, comment is required

---

**Provider’s PRINTED Name, Address, and Phone Number**

---

**Provider’s Signature** Date
The Alabama College System endorses the Americans’ with Disabilities Act. In accordance with College policy, when requested, reasonable accommodations may be provided for individuals with disabilities. The essential functions delineated below are necessary for nursing program admission, progression and graduation and for the provision of safe and effective nursing care. The eligibility criteria include but are not limited to the ability to:

1) Sensory Perception
   a) Visual
      i) Observe and discern subtle changes in physical conditions and the environment
      ii) Visualize different color spectrums and color changes
      iii) Read fine print in varying levels of light
      iv) Read for prolonged periods of time
      v) Read cursive writing
      vi) Read at varying distances
      vii) Read data/information displayed on monitors/equipment
   b) Auditory
      i) Interpret monitoring devices
      ii) Distinguish muffled sounds heard through a stethoscope
      iii) Hear and discriminate high and low frequency sounds produced by the body and the environment
      iv) Effectively hear to communicate with others
   c) Tactile
      i) Discern tremors, vibrations, pulses, textures, shapes, size, location and other physical characteristics
   d) Olfactory
      i) Detect body odors and odors in the environment

2) Communication/Interpersonal Relationships
   a) Verbally and in writing, engage in a two-way communication and interact effectively with others, from a variety of social, emotional, cultural and intellectual backgrounds
   b) Work effectively in groups
   c) Work effectively independently
   d) Discern and interpret nonverbal communication
   e) Express one’s ideas and feelings clearly
   f) Communicate with others accurately in a timely manner
   g) Obtain communications from a computer

3) Cognitive/Critical Thinking
   a) Effectively read, write and comprehend the English language
   b) Consistently and dependably engage in the process of critical thinking in order to formulate and implement safe and ethical nursing decisions in a variety of health care settings
   c) Demonstrate satisfactory performance on written examinations including mathematical computations without a calculator
   d) Satisfactorily achieve the program objectives

4) Motor Function
   a) Handle small delicate equipment/objects without extraneous movement, contamination or destruction
   b) Move, position, turn, transfer, assist with lifting or lift and carry clients without injury to clients, self or others
   c) Maintain balance from any position
   d) Stand on both legs
   e) Coordinate hand/eye movements
   f) Push/pull heavy objects without injury to client, self or others
   g) Stand, bend, walk and/or sit for 6-12 hours in a clinical setting performing physical activities requiring energy without jeopardizing the safety of the client, self or others
   h) Walk without a cane, walker or crutches
   i) Function with hands free for nursing care and transporting items
   j) Transport self and client without the use of electrical devices
   k) Flex, abduct and rotate all joints freely
   l) Respond rapidly to emergency situations
   m) Maneuver in small areas
   n) Perform daily care functions for the client
   o) Coordinate fine and gross motor hand movements to provide safe effective nursing care
   p) Calibrate/use equipment
   q) Execute movement required to provide nursing care in all health care settings
   r) Perform CPR and physical assessment
   s) Operate a computer

5) Professional Behavior
   a) Convey caring, respect, sensitivity, tact, compassion, empathy, tolerance and a healthy attitude toward others
   b) Demonstrate a mentally healthy attitude that is age appropriate in relationship to the client
   c) Handle multiple tasks concurrently
   d) Perform safe, effective nursing care for clients in a caring context
   e) Understand and follow the policies and procedures of the College and clinical agencies
   f) Understand the consequences of violating the student code of conduct
   g) Understand that posing a direct threat to others is unacceptable and subjects one to discipline
   h) Meet qualifications for licensure by examination as stipulated by the Alabama Board of Nursing
   i) Not to pose a threat to self or others
   j) Function effectively in situations of uncertainty and stress inherent in providing nursing care
   k) Adapt to changing environments and situations
   l) Remain free of chemical dependency
   m) Report promptly to clinical and remain for 6-12 hours on the clinical unit
   n) Provide nursing care in an appropriate time frame
   o) Accepts responsibility, accountability, and ownership of one’s actions
   p) Seed supervision/consultation in a timely manner
   q) Examine and modify one’s own behavior when it interferes with nursing care or learning.

STUDENT STATEMENT
Read the declarations below and sign only one option. If you are unable to fully meet any criterion, you will need to direct your request to the Services of Special Populations.

I have reviewed the Eligibility Criteria for this program and I certify that to the best of my knowledge – I currently have the ability to fully perform these functions. I understand that further evaluation of my ability may be required and conducted by the nursing faculty if deemed necessary to evaluate my ability prior to admission to the program and for retention and progression through the program.

I have read the Eligibility Criteria for this program and I currently am unable to fully meet the items indicated without accommodations. I am requesting the following reasonable accommodations: (Use additional sheet for request)

Signature ____________________________
Date ____________________________

MEDICAL VERIFICATION
Is this person’s mental and physical health sufficient to perform the classroom and clinical duties of a nursing student?

YES_____ NO_____ If no, please explain (use additional sheet if needed.)

MD/PA/NP Signature ____________________________ Date ____________________________

Printed Name ____________________________
# Proof of Vaccination/Immunization

<table>
<thead>
<tr>
<th>Program (Circle one)</th>
<th>Dental Assistant</th>
<th>EMT Basic</th>
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<td></td>
</tr>
</tbody>
</table>

## TB Skin Test (2-step) within the past 6 months

<table>
<thead>
<tr>
<th>Step</th>
<th>Date Admin</th>
<th>Date Read</th>
<th>Results: mm of induration</th>
<th>If positive PPD, Chest X-Ray</th>
<th>T-Spot</th>
<th>Quantiferon test</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Adult Tetanus Vaccination (Td or Tdap) within the past 10 years

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Vaccination Dates</th>
<th>Titer*</th>
<th>Date</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd Dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Varicella (Chicken Pox)
Evidence of Immunity includes any one of the following:
- Positive Titer (*with lab documentation)
- Two doses of the vaccine

### MMR (Measles, Mumps, and Rubella)
Evidence of Immunity includes any one of the following:
- Positive Titers (*with lab documentation)
- Two doses of the vaccine

### Hepatitis B
Evidence of Immunity includes any one of the following:
- Positive Titer (*with lab documentation)
- Three doses of the vaccine

## Hepatitis B Vaccination Statement

(To be completed only if the Hepatitis B Vaccine is declined or if the series has not been completed)

I have read the Hepatitis B Vaccination information provided by the Calhoun Community College Health Division. I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. Understanding the foregoing, I accept responsibility for my decision regarding the HBV vaccine. I agree to hold Calhoun Community College and all of its agents, officials, or employees harmless if I should contract this disease during or after my attendance at Calhoun Community College.

Please Check one option:

- I **DO NOT** consent to the administration of the vaccine. I understand the risks involved and I take full responsibility of any actual or potential hazards to my health.
- I have begun the Hepatitis B vaccination series. I understand the risks involved and I take full responsibility for completing the series on time and submitting the documentation to Calhoun Community College.

Student Signature: ___________________________  Date: ____________

I certify this student has received the TB test and immunizations as indicated above or has laboratory evidence of immunity, which is attached to this form.

---

Print Name of Health Care Provider: ___________________________  Signature of Provider (MD, DO, CRNP, PA): ___________________________  Date: ____________

Facility Name, Address, City, State, Zip: ___________________________  Phone Number: ____________
This page is intentionally left blank
### Division of Health

#### Identification and Certification Cards

<table>
<thead>
<tr>
<th>Student Name (Last, First MI)</th>
<th>Telephone</th>
<th>Student Number (C#)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Program (Circle one)**

- Dental Assistant
- Paramedic
- EMT Basic
- Physical Therapist Assistant
- Medical Lab Tech
- Surgical Technology
- Nursing

**Insurance Card / Waiver**

- Copies of your health insurance cards, a letter from your insurance provider, or a signed waiver is required.

**Please attach a copy of your health insurance card**

If you choose not to have Insurance, please sign the waiver of liability below.

### Health Insurance Policy

Please initial each of the following statements:

1. I understand that, as a Health Division student at Calhoun Community College, it is strongly recommended that I have health insurance.

2. I understand that if I experience injury or illness as a student fulfilling educational activities at a clinical facility, emergency treatment will be provided by that facility **at my expense**.

3. I understand that if I experience injury or illness as a student fulfilling educational activities while on campus, emergency treatment will be **at my choice and at my expense**.

4. With knowledge and understanding, and on behalf of myself, my heirs, and administrators, I hereby release Calhoun Community College, its employees, officials, agents, and representatives from any claim of liability for injury, loss, damage, or death that may result or arise from my experience as a student of the Health Sciences Division.

Please choose one option:

- **[ ]** I have chosen **to provide proof of Health Insurance coverage** while enrolled in one of the Health Sciences programs and have supplied a copy of my insurance card to the Health Division.
- **[ ]** I have been informed of the importance of this recommendation and have elected to sign this waiver, verifying that I have **chosen not to have health insurance coverage**.

**Student Signature**

______________
Date

### CPR Certification

Your Basic Life Support CPR certification must be issued by one of the following and valid for a minimum of 12 months:

- American Heart Association BLS for Healthcare Providers
- American Red Cross BLS Healthcare Provider, or
- ASHI BLS for Healthcare Providers and First Responders.

Please submit a copy of your CPR card.

If you have an ecard, you may email the card to your program secretary below.

**Nursing classes:**
- DJ Doorenbos
dj.doorenbos@calhoun.edu 256-306-2794

**Allied Health classes:**
- Misty Greene
misty.greene@calhoun.edu 256-306-2786

### Valid Photo ID

This may be a driver’s license, passport, or military ID.

### Calhoun CC Student ID

Student IDs are available at the Decatur and Huntsville campuses and will be part of your program uniform. Please visit [http://www.calhoun.edu/student-resources/student-id-card-system](http://www.calhoun.edu/student-resources/student-id-card-system).
Division of Health Sciences
Influenza Vaccination Form

Please PRINT

Student NAME  C #  Program

I have read the attached information about the flu and flu vaccine. I understand there is no guarantee that I will become immune or that I will not experience an adverse side effect from the vaccine. I request the flu vaccine be given to me. I agree not to hold CCC or its employees responsible for any problems I may have from receiving the flu vaccine. I realize that the decision to take the flu vaccine is totally voluntary on my part.

Please answer the following questions:

YES  NO

1. Do you have a severe life threatening allergy to eggs or egg products?

2. Are you allergic to thimerosal (a preservative) other than contact lens solution sensitivity?

3. Have you ever had Guillain-Barre Syndrome within 6 weeks of taking a flu shot?

4. Have you ever had an anaphylactic reaction to the influenza vaccine?

5. Are you allergic to Gentamycin sulfate?

6. Are you pregnant?

Please choose one option:

☐ I choose to be vaccinated at this time. I have read and fully understand the information on this form.

☐ (Dental Assistant Program students only) I choose to decline vaccination at this time. I may change my mind and accept vaccination later, if vaccine is available. I have read and fully understand the information on this form.

Student Signature: _____________________________  Date: _____________________________

Name of Facility dispensing the Seasonal Flu Vaccination (ie, Doctor’s Office, Pharmacy, Clinic)

______________________________________________________________

Phone Number: _____________________________

I, _____________________________, administered the Seasonal Flu Vaccination to the
(Person administering the vaccination)

student listed above on _____________________________.

Injection Site:  R Deltoid  L Deltoid

(circle one)  (circle one)

Date

Facility Stamp or address  Signature