

**MARICOPA COMMUNITY COLLEGE DISTRICT NURSING PROGRAM
HEALTH AND SAFETY DOCUMENTATION CHECKLIST**

Applicant: _____ Student ID _____ Date: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

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 & results of titer: Measles/Rubeola _____ Mumps _____ Rubella _____

Circle: Yes or No I have attached documented proof as specified above.

A. 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: _____

Circle: Yes or No I have attached documented proof as specified above.

B. Tetanus/Diphtheria (Td) immunization within the past 10 years. Td Date: _____

Circle: Yes or No I have attached documented proof as specified above.

C. Tuberculosis: Documentation of an initial **Two-Step TB skin test** (PPD) and annual Update of TB skin test. If positive skin test, provide documentation of chest X-ray within the last 2 years, and annual documentation of a TB disease free status. **All skin testing must have been completed within the previous six (6) months.**

Initial Test: Date: _____ Date of Reading: _____ Results (circle): Negative **OR** Positive
AND

Boosted Test: Date: _____ Date of Reading: _____ Results (circle): Negative **OR** Positive
OR

Annual Update: Date: _____ Date of Reading: _____ Results (circle): Negative **OR** Positive
OR

Chest x-ray Date: _____ Results: _____ Date of Symptom Sheet _____

Circle: Yes or No I have attached documented proof as specified above.

D. Hepatitis B: Documented evidence of completed series or positive antibody titer. If beginning series, first injection must be prior to admission, the second in one month and third in 6 months.

Date of 1st injection: _____ **OR** Hep B Titer Date: _____

Date of 2nd injection: _____ Titer Results: _____

Date of 3rd injection: _____ **OR** HBV Vaccination Declination Form Date: _____

Circle: Yes or No I have attached documented proof as specified above.

F. CPR Card: Date CPR card Issued: _____ Expiration Date: _____

Circle: Yes or No I have attached a copy of both sides of the CPR Card. CPR certification must remain current through the semester of enrollment.

G. Fingerprint Clearance Card: Date Card Issued: _____ Expiration Date: _____

Circle: Yes or No I have attached a copy of both sides of the Fingerprint Clearance Card current through the semester of enrollment.

MARICOPA COMMUNITY COLLEGE DISTRICT NURSING PROGRAM

Health Care Provider Signature Form

Instructions for Completion of Health Care Provider Signature Form

A health care provider **must** sign Health Care Provider Signature Form **within 12 months of application** and indicate whether the applicant will be able to function as a nursing student. Health care providers who qualify to sign this declaration include a licensed physician (M.D., D.O.), a nurse practitioner, or physician's assistant.

(Please Print)

Applicant Name _____ Student ID Number _____

It is essential that nursing students be able to perform a number of physical activities in the clinical portion of the program. At a minimum, students will be required to lift patients, 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 direct patient care. The clinical nursing 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. Individuals should give careful consideration to the mental and physical demands of the program prior to making application.

I believe the applicant _____ WILL OR _____ WILL NOT be able to function as a nursing student as described above.

If not, explain: _____

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

Print Name: _____ Title: _____

Signature: _____ Date: _____

Address: _____

City: _____ State: _____

Phone: _____

MARICOPA COMMUNITY COLLEGE DISTRICT NURSING PROGRAM

INSTRUCTIONS FOR COMPLETING HEALTH AND SAFETY FORMS

IMPORTANT: All students placed in the MCCDNP must provide documentation of compliance for the vaccinations and TB testing required to protect patient safety. Only students providing documentation of health and safety requirements are enrolled in nursing courses. The Nursing Department will accept only photocopies of all documentation of health related materials. Students are responsible for maintaining their records and must submit documentation when due. All immunization records must include your name and signature of the healthcare provider. A health care provider's signature on the Health Declaration form, without proof of immunization status, is NOT acceptable.

REQUIREMENTS

A. MMR (measles/rubeola, mumps, rubella)

Options to meet this requirement:

- a. Attach a copy of proof of two previous MMR vaccinations to the health declaration form.

OR

- b. If you had all three illnesses OR you have received the vaccinations but have no documented proof, you must have a titer drawn for each illness.
 1. If the titer results are POSITIVE, attach a copy of the results to the health declaration form.
 2. If the titer results are NEGATIVE, you must get your first MMR vaccination and attach documentation to the health declaration form. The second MMR must be completed within one month and proof submitted to the nursing department.

B. Varicella (chickenpox)

Options to meet this requirement:

- a. Attach a copy of proof of a positive IgG titer for varicella.

OR

- b. If the titer is NEGATIVE, attach a copy of proof to the health declaration form that you received the first vaccination. Complete the second vaccination in 4 to 8 weeks and submit proof to the nursing department.

C. Tetanus/Diphtheria (Td) immunization within the past 10 years. Attach a copy of proof of Td vaccination.

D. Tuberculosis (TB)

- a. Attach a copy of proof of an initial two-step TB skin test (PPD). Submit the initial result and the 2nd result of test given 1 to 3 weeks later. If you have the initial 2-step test, include the annual update within the last 6 months. Records for skin testing for TB require name and signature of the healthcare provider.

Source: *Core Curriculum on Tuberculosis What the Clinician Should Know*, Dept of Health and Human Services, Center for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Division of Tuberculosis Elimination, Atlanta, Georgia, 4th Ed. 2000.

OR

- b. If positive skin test, provide documentation of chest X-ray within the last 2 years and annual documentation of a TB disease free status by completing the Tuberculosis Screening Questionnaire.

E. Hepatitis B

If you have not received the injections in the past, do not test for titer. You must obtain the first injection and attach a copy of proof of the injection to the health declaration form. You must receive the 2nd injection in one month and the 3rd five months after the second. Submit documentation to the nursing department.

- a. Attach a copy of proof of completion of three Hepatitis B injections to the health declaration form.

OR

- b. If received entire series, attach a copy of proof of a positive HbsAB antibody titer to the health declaration form.

OR

- c. Signed Hepatitis B Virus (HBV) Vaccination Declination Form

F. CPR Card:

Attach a copy of both sides of the CPR card to this form. CRP certification must include infant, child, and adult, 1 and 2 man rescuer, and evidence of a land-based demonstration component. **CPR certification** must remain current through the semester of enrollment.

G. Fingerprint Clearance Card:

Attach a copy of the front and back of the Fingerprint Clearance Card. The Fingerprint Clearance Card must remain current through the semester of enrollment.