INSTRUCTIONS FOR SUBMITTING THE REQUIRED HEALTH FORMS
GENERAL INFORMATION

- The purpose of these health requirements is to protect students/faculty as well as the patients with whom they will be working from vaccine-preventable and other communicable diseases.

- Read all instructions, and form(s) thoroughly.

- Make an appointment to see a healthcare provider (physician, certified nurse practitioner or physician assistant) during the timeframes listed below. Please call to schedule your appointment now to allow time for completion of the form(s) and to avoid delays in beginning clinical.
    - For the **Fall** semester: ***between July 1st – August 8th***
    - For the **Spring** semester: ***between November 1st-November 30th***

- The **Annual Health Clearance** form must be completed on a **yearly** basis for all clinical courses. Annual Health Clearance is inclusive of History and Physical, and Tuberculosis Screening.

- The **Influenza Vaccine Documentation** form must be completed on a **yearly** basis for all clinical courses. Influenza vaccine documentation can be submitted from the start of seasonal availability of the current season's flu vaccine.

- The **Immunization Documentation form** needs to be **completed only one time**, upon entry into the program.

- Students/faculty members **MUST SIGN** the section of the forms indicating understanding need for health care requirements and authorizing Brookdale Community College to release information to any health care provider which requires it in connection to participation in a clinical course.

- Persons opting to waive the hepatitis vaccine must sign the associated waiver. Persons who have *not completed* the hepatitis vaccine series must also sign the waiver.

- Check your form(s) carefully for required signatures and to assure presence of appropriate titer levels. It is the student/faculty responsibility to submit complete forms by the submission deadline.
- No other forms will be accepted.
- The **deadline** for submission of forms for the Fall semester is: **August 15th**.
- The **deadline** for submission of forms for the Spring semester is: **December 11th**.
- Students who do not submit completed Annual Health Clearance forms or Immunization Documentation forms by the required date will **not** be permitted to attend clinical laboratory. Absences from clinical place students at risk for course failure and can only be made up according to program policies.

Updated 4.9.19 JE

ANNUAL HEALTH CLEARANCE REQUIREMENTS

The Annual Health Clearance form needs to be completed on a yearly basis for all clinical courses. To be in compliance:

- The student/faculty member must sign the section of the form indicating understanding need for health care requirements and authorizing Brookdale Community College to release information to any health care provider which requires it in connection to participation in a clinical course
- The health care provider must verify that the applicant is in good health and can participate in clinical practice
- TB screening must be dated within 6 months of the deadline for submission
  - Negative two-step skin test administered 1-3 weeks apart OR
  - 2 negative skin tests administered within 12 months of each other OR
  - Negative IGRA
    - If the skin test or IGRA is Positive/Indeterminate
      - Chest x-ray report must be attached
      - Annual completion of risk assessment must be documented on health clearance form
      - If chest x-ray report is Positive, documentation of medication is required on health clearance form

NURSING/ALLIED HEALTH IMMUNIZATION DOCUMENTATION

The Immunization Documentation form needs to be completed only one time. To be in compliance:

- The student/faculty member must sign the section of the form indicating understanding need for health care requirements and authorizing Brookdale Community College to release information to any health care provider which requires it in connection to participation in a clinical course.
- The HCP must document the date of Tetanus/Diphtheria/Pertussis Vaccine administered within 10 years.
- The HCP must document students (regardless of age) have immunity to Measles (Rubeola), Mumps, Rubella (German measles), and Varicella (Chickenpox). Evidence may include either
  - Documented proof of completion of immunization series, OR
  - Positive titers (laboratory blood tests to detect antibodies) for each disease
    - VERBAL HISTORY OF DISEASE IS **NOT** ACCEPTABLE
  - If using titers to demonstrate immunity to Measles, Mumps, Rubella, and/or Varicella, the **lab reports need to be submitted as proof of immunity.**
  - If titers for Measles, Mumps, Rubella are negative or equivocal, the student/faculty must provide evidence of vaccination with two doses of MMR OR Two doses of Measles, Two doses of Mumps, and one dose of Rubella dated after the date of the negative or equivocal titer.
  - If titer for Varicella is negative or equivocal, the student/faculty must provide evidence of vaccination with two doses of vaccine at least 28 days apart AND received after the date of the negative or equivocal titer(s).
- The HCP must document titers that demonstrate immunity to Hepatitis B. Evidence is a positive titer. If titer is not positive, the HCP should document received after the date of the negative titer. No further blood testing is required. Students should sign Hepatitis B Vaccination waiver if vaccination series is not complete or if vaccination is declined.

BROOKDALE COMMUNITY COLLEGE
NURSING/ALLIED HEALTH ANNUAL HEALTH CLEARANCE

To be completed and signed by student/faculty:

NAME: _____ DATE OF BIRTH: (mm/dd/yyyy)_____

STUDENT ID #: _____ PROGRAM: ☐Nursing ☐Respiratory Care ☐Rad Technology ☐Other PHONE #:_____

SEMESTER/YR: _____ EMAIL: _____

I understand I must meet all health care requirements mandated by the NJ Dept. of Health and the JCAHO for employees of any health care facility. I understand the agency to which I am assigned may require more health data than listed below. I hereby authorize Brookdale Community College to release my health clearance and immunization documentation (including laboratory reports and immunizations waivers) to any health care agency which may require it in connection with my participation in a clinical course. I also understand that it is my responsibility to update my Annual Health Clearance form annually. I have provided the original of the required completed/signed health clearance documents and kept an additional copy for my own record.

Student Faculty/Signature: _____

To be completed and signed by health care provider:

History and Physical

- By signing below, I have determined that the named individual is eligible for clinical practice and agree with the following statements: I find him/her to be in good physical and mental health; he/she is free from any health impairment which is of potential risk to patients, personnel, students or faculty and which might interfere with the performance of his/her nursing or allied health career responsibilities

Tuberculosis Screening

Either a Mantoux TB (PPD) skin test *or* an interferon gamma release assay (IGRA) blood test such as QuantiFERON TB Gold is acceptable

- If submitting a PPD:
  An initial 2-step PPD (Mantoux) skin test is required (2 PPD tests done one to three weeks apart) unless a PPD was done within the last calendar year, after completing the 2-step PPD.
- If IGRA test is performed, laboratory report and test results must be submitted

PPD (Mantoux) # 1: Date Administered: _____ **Date Read:** _____ ☐**Negative** ☐ **Positive**

PPD (Mantoux) # 2: Date Administered: _____ **Date Read:** _____ ☐**Negative** ☐ **Positive**

OR

IGRA: Date Administered _____ **(must be within past 12 months)** ☐**Report Attached** ☐**Negative** ☐**Positive** ☐ **Indeterminate** (positive/indeterminate findings require repeat testing)

PPD or IGRA Positive/Indeterminate Findings

Negative chest X-Ray report within 12 months of starting program is required. This is a one-time only requirement as long as patient is asymptomatic. X-Ray report must be attached

- **Date of Chest X-Ray** _____ ☐ **X-Ray report attached** ☐**Normal X-Ray** ☐ **Abnormal X-Ray**
- ☐ **Annual completion of risk assessment shows patient is asymptomatic**
- **If abnormal X-Ray: Patient was/is treated with prophylactic medications. Date treatment started** _____

Annual Influenza Vaccine*

See Student/Faculty Influenza Vaccine Documentation form

Signature of health care provider: _____ **Date:** _____

Print name: _____

License #: _____ **Phone #:** _____

Address: _____

Updated 2.27.17 JE

BROOKDALE COMMUNITY COLLEGE

NURSING/ALLIED HEALTH IMMUNIZATION DOCUMENTATION

To be completed and signed by student/faculty:

NAME: _____ DATE OF BIRTH: (mm/dd/yyyy)_____

STUDENT ID #: _____ PROGRAM: ☐ Nursing ☐ Respiratory Care ☐ Rad Technology ☐ Other PHONE #:_____

SEMESTER/YR: _____ EMAIL: _____

I understand I must meet all health care requirements mandated by the NJ Dept. of Health and the JCAHO for employees of any health care facility. I understand the agency to which I am assigned may require more health data than listed below. I hereby authorize Brookdale Community College to release my health clearance and immunization documentation (including laboratory reports and immunizations waivers) to any health care agency which may require it in connection with my participation in a clinical course. I also understand that it is my responsibility to update my Annual Health Clearance form annually. I have provided the original of the required completed/signed health clearance documents and kept an additional copy for my own record.

Student/Faculty Signature: _____

To be completed and signed by Health Care Provider (HCP):

<table>
<tr><td>TETANUS/DIPTHERIA/PERTUSSIS
(WITHIN LAST 10 YEARS)</td><td colspan="5">DATE OF LAST Tdap: _____
Mm/dd/yyyy</td></tr>
<tr><td rowspan="5">MMR
Evidence of immunity includes either of the following:
• Positive titer OR
• Health Care Provider verified administration of two MMR vaccinations.</td><td colspan="3">MUST ATTACH LAB RESULTS MMR TITERS</td><td colspan="2" rowspan="2">If born in 1957 or later, 2 doses of MMR given on or after the first birthday, separated by 28 days or more.</td></tr>
<tr><td>Titers</td><td>IgG Titer Value</td><td>Does Titer Constitute Immunity?</td></tr>
<tr><td>Measles</td><td></td><td>☐ YES ☐ NO</td><td>MMR #1
mm/dd/yyyy</td><td>MMR #2
mm/dd/yyyy</td></tr>
<tr><td>Mumps</td><td></td><td>☐ YES ☐ NO</td><td rowspan="2"></td><td rowspan="2"></td></tr>
<tr><td>Rubella</td><td></td><td>☐ YES ☐ NO</td></tr>
<tr><td rowspan="3">VARICELLA (chicken pox)
Evidence of immunity includes either of the following:
• Positive titer OR
• Health Care Provider verified administration of two varicella vaccinations.</td><td colspan="3">MUST ATTACH LAB RESULTS VARICELLA TITER</td><td rowspan="2">Varicella Vaccination #1
mm/dd/yyyy</td><td rowspan="2">Varicella Vaccination #2
mm/dd/yyyy</td></tr>
<tr><td rowspan="2">Varicella</td><td>IgG Titer Value</td><td>Does Titer Constitute Immunity?</td></tr>
<tr><td></td><td>☐ YES ☐ NO</td><td></td><td></td></tr>
<tr><td rowspan="3">HEPATITIS B
Evidence of immunity:
• Positive titer. If titer is negative, a HPC verified round of Hepatitis B series of three vaccinations received after the date of the negative titer. No further blood testing required after series OR
• Signed Hepatitis B Vaccination Waiver</td><td colspan="3">MUST ATTACH LAB RESULTS HEPATITIS B SURFACE ANTIBODY (HBsAB) TITER</td><td>Hepatitis B Vaccination #1
mm/dd/yyyy</td><td>Hepatitis B Vaccination # 2
mm/dd/yyyy</td><td>Hepatitis B Vaccination #3
mm/dd/yyyy</td></tr>
<tr><td rowspan="2">Hepatitis B</td><td>Titer Value</td><td>Does Titer Constitute Immunity?</td><td></td><td></td><td></td></tr>
<tr><td></td><td>☐ YES ☐ NO</td><td colspan="3">Submission of a signed Hepatitis B waiver is required for series in progress</td></tr>
</table>

Signature of Health Care Provider: _____ **Date:** _____

Print name: _____

License #: _____ **Phone #:** _____

Address: _____

Updated 4.25.19 JE

HEPATITIS B VACCINATION WAIVER

Brookdale Community College

Student/Faculty Name: _____ BCC ID # _____

PROGRAM: _____

I understand that due to my occupational exposure to blood and other potentially infectious materials I may be at risk of acquiring Hepatitis B Virus (HBV) infection, a serious disease.

Please check the appropriate statement:

☐ I have been given the opportunity to be vaccinated. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B.

☐ I am currently in the process of receiving the 3-dose series of Hepatitis B vaccine at 0, 1 and 6 month intervals. I will obtain anti-HB serologic testing one to two months after dose # 3. Until this process is completed, I have been informed and understand that I continue to be at risk of acquiring Hepatitis B.

Signed: _____

Print Name: _____

Date: _____

STUDENT/FACULTY INFLUENZA VACCINE DOCUMENTATION

Brookdale Community College

Student/Faculty Name: _____ ID # _____ Course/Section # _____

PROGRAM: _____

Influenza Facts for all to know:

- Influenza is a serious disease. More than 200,000 people are hospitalized each year with flu complications and approximately 36,000 people, of all ages, die from the flu each year.
- You cannot get the flu from the flu vaccine.
- You should get the flu shot if you are pregnant or planning on becoming pregnant.
- Inactivated vaccines are available for people 6 months of age and older.
- The flu vaccine is the most effective way to prevent the flu. Covering your cough with your arm and frequent hand washing helps stop the spread of disease.
- The flu vaccine protects against 3 – 4 strains or types of influenza. Every year research is done to determine which types will be in the vaccine.
- You can spread the flu to others before you are feeling ill or know that you have the flu. The flu is spread through coughs and sneezes, as well as by contact with contaminated hands.
- The stomach flu is not influenza. The main symptoms of influenza are fever, headache, extreme tiredness, dry cough, sore throat and muscle aches.

Flu Immunization is required annually with this season's currently recommended influenza vaccine OR the student/faculty must sign the Flu Vaccination Waiver below.

Verification of flu vaccine must be attached.

Flu vaccine:

Date Received: _____

Place of Vaccination: _____

Name of Provider _____

FLU VACCINATION WAIVER

I understand that Influenza vaccination is required for all health care workers to prevent influenza disease and its complications, including death. I understand the strains of virus that cause influenza infection change almost every year, which is why a different influenza vaccine is recommended each year. The consequences of my refusing to be vaccinated could endanger my health and health of those with whom I am in contact with. Persons who qualify for a medical exemption must wear a mask in patient care areas and as otherwise advised by the specific health care institution. My signature below indicates that I decline to receive the vaccine.

Reason for declination

I have a medical contraindication – (The only medical contraindications are SEVERE egg allergies, or a history of Guillain-Barre Syndrome. Medical documentation must be provided)

☐Egg allergy
☐History of Guillain-Barre syndrome

Signed: _____

Print Name: _____ Date: _____

3-2-17je