Providers who may complete this form: Physician, Physician's Assistant, Nurse Practitioner

Skyline COLLEGE

ALLIED HEALTH PROGRAM REPORT OF HEALTH SCREENING

(Admin. Medical Assisting, Central Service Tech, Surgical Tech, Anesthesia Tech)

TO BE COMPLETED BY THE STUDENT

Name_____ Social security #: _____-_____-_____

Gender: _____ M _____ F Birth date: _____ / _____ / _____

Address: _____

City: _____ Zip: _____ Phone: ( )_____ - _____

TO BE COMPLETED BY THE EXAMINING HEALTH CARE PROVIDER

HT:_____ WT:_____ Temp:_____ Pulse:_____ BP:_____

Resp:_____ Heart:_____ Lungs:_____

Ears – R:_____ L:_____ Eyes – R:_____ L:_____ Corrected Vision:_____

Mouth:_____ Teeth:_____ Glands:_____ Skin:_____

Spine:_____ Neuro:_____ Extremities:_____ Vessels:_____

Abd:_____ Inguinal Rings:_____ Pelvic:_____* Breasts:_____

Allergies:_____

* May be deferred

The person named above is free of communicable disease at this time: Yes_____ No_____

Remarks:_____

_____

_____

The patient appears capable of performing the physical activities of the Allied Health Program as described on page #1 of this form: Yes_____ No_____

Remarks:_____

_____

_____ _____ _____ _____

Please Print Examiner Name ***Signature*** ***License Number*** ***Date Completed***

_____

Examiner's Address

_____

Student's Signature (Gives permission to release immunization records to affiliating clinical facilities.)

Providers who may complete this form: Physician, Physician's Assistant, Nurse Practitioner, Registered Nurse

Skyline COLLEGE

ALLIED HEALTH PROGRAM REQUIRED IMMUNIZATIONS/ TITERS

(Admin. Medical Assisting, Central Service Tech, Surgical Tech, Anesthesia Tech)

Name: _____ Student ID: _____

PPD, or QUANTEFERON or CHEST X-RAY, and **ALL TITERS** with evidence of a positive response must be completed prior to entry into the SECOND SEMESTER of the health program. (**Note: PPD or Chest X-ray** must be completed **no more than FOUR WEEKS prior to entry**. If the Hepatitis B vaccine is needed, the **first and second doses must be recorded prior to the second semester.**

PLEASE NOTE:

- These tests, immunizations and physical exam are required by the hospitals to which the students are assigned.
- Documentation and completion of these requirements are the responsibility of the student.
- Dismissal from the Program WILL result if documentation is not complete within the required time frame.
- Seasonal Influenza will be required each fall/winter season

TB PPD (2 tests) DATE: _____ RESULTS: _____
DATE: _____ RESULTS: _____
OR Quanteferon DATE: _____ RESULTS: _____
Chest X-ray, if positive skin test DATE: _____ RESULTS: _____

RUBELLA (German Measles) Positive Titer- DATE: _____ RESULTS: _____
If **negative**, MMR w/ live vaccine MMR DATE: _____
Follow-up Titer: DATE: _____ RESULTS: _____
RUBEOLA (Measles) Positive Titer- DATE: _____ RESULTS: _____
If **negative,** MMR w/ live vaccine MMR DATE: _____
Follow-up Titer: DATE: _____ RESULTS: _____
MUMPS: Positive Titer- DATE: _____ RESULTS: _____
If **negative**, MMR w/ live vaccine MMR DATE: _____
Follow-up Titer: DATE: _____ RESULTS: _____

VARICELLA (Chicken Pox) Positive Titer- DATE: _____ RESULTS: _____
If **negative**, vaccines required DATE: _____ DATE: _____
Follow-up Titer: DATE: _____ RESULTS: _____

Tdap
Booster required every ten (10) years: DATE: _____

HEPATITIS B Vaccine
Positive Titer: DATE: _____ RESULTS: _____
If **negative**, immunization required.
(Schedule: 2nd dose due one month FIRST DOSE DATE: _____
after 1st; 3rd due 6 months after 2nd; SECOND DOSE DATE: _____
Follow-up titer 8 weeks after 3rd) THIRD DOSE DATE: _____
Follow-up Titer: DATE: _____ RESULTS: _____

SEASONAL INFLUENZA: DATE: _____
ADDITIONAL INFLUENZA (PRN): TYPE: _____ DATE: _____

_____ _____ _____ _____
Please Print Heathcare Provider Name ***Signature*** ***License Number*** ***Date Completed***