**WCTC School of Health**
800 Main Street
Pewaukee, WI 53072
262.691.5091 (Phone)

# Nursing Assistant Acute Care Hospital Clinical Student Health Requirements

**1.**

| Student's Last Name | First Name | M.I. | Date of Birth | Student ID# | Program **Nursing Assistant** |
|---|---|---|---|---|---|
| | | | | | |

**A Physician, Nurse Practitioner, Physician's Representative, or Qualified Health Care Provider (QHCP) must fill in appropriate information in each category.**

**It is the responsibility of the student to ensure that all Health Requirements are up-to-date prior to each clinical experience.**

**2.**

| **Physical Exam** |
|---|
| A physical exam is to take place within one year of starting clinical experiences. |
| Date of exam QHCP signature |

**3.**

| **Tuberculin (TB) Skin Test - INITIAL TESTING** (If you have had TB skin test within the last 12 months, skip this step and proceed to step 4) |
|---|

**3a.**

| **2-Step Tuberculin (TB) Skin Test** If student has **not** had a TB skin test within the last 12 months, a 2-step TB skin test is required. Documented proof of negative results on two separate skin tests administered 7 - 21 days apart. The time between each administration and reading is 48 to 72 hours. | | | | | |
|---|---|---|---|---|---|
| **Test 1** | | | **Test 2** | | |
| Date given: | Time given: | | Date given: | Date read: | Results: |
| Date read: | Time read: | Results: | Date read: | Time read: | Results: |
| QHCP Signature: | | | QHCP Signature: | | |

**OR**

**3b.**

| **Students can have a Quantiferon test in place of the skin test** If positive, they will need to have an annual symptom review by a Quantiferon Health Care Provider, which may require a chest x-ray. | | | |
|---|---|---|---|
| **Quantiferon Blood Test** | | **Annual Symptom Review** (for positive reactions) | |
| Date: | Results: | Date: | Results: |

**4.**

| **Tuberculin (TB) Skin Test - ANNUAL TESTING** (for students who have already completed their initial testing) | | |
|---|---|---|
| **2-Step Tuberculin (TB) Skin Test or Quaniferon Test** | | |
| **Year** | | |
| Date given: | Date read: | Results: |

**5.**

| **Tetanus, Diphtheria and Pertussis (Tdap)** |
|---|
| Documentation of one time dose of the Tdap vaccine and then Td every ten (10) years. |
| Date of last booster/immunization: |

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# Nursing Assistant Acute Care
# Student Health Requirements (continued)

**6. Measles/Mumps/Rubella (MMR)** Documented proof of **one** of the following:

**Serologic immunity (Positive Titer)**

| **Rubella Titer** | | **Mumps Titer** | |
|---|---|---|---|
| Date given: | Results: | Date given: | Results: |
| **Measles Titer** | | | |
| Date given: | Results: | | |

**OR 6b. MMR vaccines**
Receipt of two (2) MMR vaccines appropriately spaced and according to CDC guidelines (on or after first birthday and at least 28 days apart).

| Date 1: | Date 2: |
|---|---|

**7. Varicella Immunization** Documented proof of **one** of the following:

**Serologic immunity (Positive Titer)**

| Date given: | Results: |
|---|---|

**OR 7b. Varicella vaccines**
Receipt of two (2) MMR vaccines appropriately spaced and according to CDC guidelines (on or after first birthday and at least 28 days apart).

| Date 1: | Date 2: |
|---|---|

**8. Hepatitis B** Documented proof of **one** of the following:

**Serologic immunity (A numeric Hepatitis B antibody level that indicate immunity)**

| Date given: | Results: |
|---|---|

**OR 8b. Student is in the process of receiving the three (3) dose Hepatitis B vaccination series**
Appropriately spaced and according to CDC guidelines.

| Date 1: | Date 2: | Date 3: |
|---|---|---|

**OR 8c. A signed Hepatitis B Vaccine Declination statement**
Obtain form from WCTC faculty.

**9. Annual Flu Vaccine** Influenza vaccination is required for all students scheduled to be in a clinical site between 10/1 and 3/31.

Date given:

**10. Student Validation and Signature**

I understand that the information provided on this form may be shared with WCTC-associated clinical and field sites and consent to its release. I understand that WCTC cannot guarantee allergen-free clinical or field sites. I further affirm that the information contained within this form is true and accurate.

_____

Student's signature Date

**11. Health Care Provider/Designee Signature**

_____

QHCP signature Date

**WCTC Use Only:**

_____

Nursing faculty signature Date

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