

**INCOMING HEALTH CAREER STUDENT HEALTH EXAMINATION  
PLEASE PRINT ALL INFORMATION**

<b>Name:</b>	<b>HACC ID:</b>	<b>Date:</b>
<b>Hawkmail Address:</b>	<b>Phone:</b>	<b>DOB:</b>

**STUDENT INFECTIOUS DISEASE SUMMARY**

In order to participate in any clinical experience/observation where there is potential for direct patient contact (hands-on care to observing within a radius of 4 feet) it is necessary that the following information be provided and verified by your physician/nurse practitioner/physician's assistant. To meet the requirements of our affiliating clinical agencies, the following diseases, immunizations or titers **MUST** be documented.

TUBERCULOSIS STATUS (choose 1)	RUBELLA (GERMAN MEASLES) STATUS
<p><b>BLOOD TEST TB INTERFERON ASSAY</b> (must be valid for the program year) Date: _____ Results: _____ positive _____ negative If result is indeterminant, proceed with 2-Step PPD test.</p> <hr/> <p align="center"><b>OR</b></p> <p><b>BLOOD TEST TB T-SPOT</b> (must be valid for the program year) Date: _____ Results: _____ positive _____ negative                   _____ borderline _____ indeterminant If result is borderline or indeterminant, repeat assay.</p> <hr/> <p align="center"><b>OR</b></p> <p><b>2-STEP MANTOUX SKIN TEST (PPD)</b> (must be valid for the program year) <i>Tests must be read within 48 to 72 hours after administration. Please allow a minimum of 4 weeks between any PPD and administration of any live vaccine. (Per CDC guidelines)</i> Date Administered: #1 _____ Date Read: #1 _____ Result: Negative _____ Positive _____ mm _____</p> <p><i>The second test must be a minimum of 7 days and a maximum of 21 days from the read date of the first.</i> Date Administered: #2 _____ Date Read: #2 _____ Result: Negative _____ Positive _____ mm _____</p> <hr/> <p align="center"><b>OR</b></p> <p>Those students with proof of previously documented 2-step and continuous yearly testing (attach evidence): <b>Annual PPD Date:</b> _____ Result: Negative _____ Positive _____ mm _____</p> <hr/> <p><b>**POSITIVE RESULT FOR ANY OF THE TESTING METHODS ABOVE:</b> 2 View Chest X-ray (completed within 2 years of date of admission): Chest X-ray Date: _____ Chest X-ray Result: Positive or Negative (Circle one) If NEGATIVE Chest X-ray: Complete the TB Screening/Self Reporting Form yearly. <b>If POSITIVE Chest X-ray: Isoniazid Prophylaxis Rx</b> Start date: _____ Estimated End Date: _____</p>	<p>Vaccination (given with MMR) – <b>2 injections</b> live virus vaccine on or after first birthday Date(s)/Type (2 injections): 1. _____ 2. _____</p> <p><b>Booster dose recommended for those vaccinated prior to 1980.</b></p> <p align="center"><b>OR</b></p> <p><b>Rubella IgG Antibody titer</b> (only required if no proof of immunizations) Date: _____ Result: Positive _____ Negative _____</p> <p><b>Booster Doses of MMR</b> Dates: 1. _____ 2. _____</p> <hr/> <p align="center"><b>MEASLES</b></p> <p>Vaccination (given with MMR) – <b>2 injections</b> live virus vaccine on or after first birthday Date(s)/ Type (2 injections): 1. _____ 2. _____</p> <p><b>Booster dose recommended for those vaccinated prior to 1980.</b></p> <p align="center"><b>OR</b></p> <p><b>Rubeola IgG Antibody titer</b> (only required if no proof of immunizations) Date: _____ Result: Positive _____ Negative _____</p> <p><b>Booster Doses of MMR</b> Dates: 1. _____ 2. _____</p> <hr/> <p align="center"><b>MUMPS</b></p> <p>Vaccination (given with MMR) - <b>2 injections</b> live virus vaccine on or after first birthday Date(s)/ Type (2 injections): 1. _____ 2. _____</p> <p align="center"><b>OR</b></p> <p><b>Mumps IgG Antibody titer</b> (only required if no proof of immunizations) Date: _____ Result: Positive _____ Negative _____</p> <p><b>Booster Doses of MMR</b> Dates: 1. _____ 2. _____</p>

Name: \_\_\_\_\_

Date: \_\_\_\_\_

VARICELLA (CHICKEN POX) STATUS	TETANUS/DIPHTHERIA/PERTUSSIS STATUS
<b>2 Doses Varicella Vaccine given 1 month apart:</b> <b>Dates:</b> 1. _____ 2. _____ <b>* Proof/documentation of disease will not meet this criteria!</b> <b>OR</b> <b>Varicella IgG Antibody titer</b> (only required if no proof of immunizations) Date: _____ Result: Positive _____ Negative _____ <b>Booster Dose of Varicella</b> (required for negative or equivocal titer result) <b>Date:</b> 1. _____ 2. _____	<b>All students MUST show proof of 1 dose of Tdap</b> <b>Date:</b> _____ <b>If last tetanus shot is &gt;10 years old, student must have tetanus booster</b> <b>Date:</b> _____

INFLUENZA STATUS
All students are required to have the <b>annual influenza</b> vaccine if attending clinical between October and March. <b>Date Administered:</b> _____ <b>LOT #</b> _____ <b>Manufacturer</b> _____ <b>**If completion of physical form is prior to flu season, student will need to complete separate form/show verification.</b>

VISION EXAM (Snellen Eye Chart or similar exam)
Normal _____ Referred for Correction: _____* <b>*If referred for correction, will need to provide documentation of referral.</b>

REVIEW OF ESSENTIAL QUALIFICATIONS
According to my history and physical evaluation, review of immunizations and lab tests and review of the Essential Qualifications for the Health Careers Program (which are attached to this document); the student meets the essential qualifications to participate fully in the student clinical experience. <b>Yes</b> _____ <b>No</b> _____
<b>COMMENTS:</b>  Does the student have any activity limitations? <b>Yes</b> _____ <b>No</b> _____
<b>COMMENTS:</b> <b>Does this student have any medical problems with which the school should be concerned?</b> Yes _____ No _____ If yes, please identify:
<b>Is the student subject to conditions that may precipitate a medical emergency, such as:</b> Epilepsy _____ Diabetes _____ Allergies _____ Fainting _____ Heart conditions _____ Other _____ Please identify
<b>Does the student possess sufficient emotional stability to accurately perceive situations and make unimpaired observations and judgments regarding patient care in the clinical experiences of the health care program?</b> Yes _____ No _____
<b>COMMENTS:</b> Is there need for follow-up treatment? <b>Yes</b> _____ <b>No</b> _____ If yes, please specify:
Does the student require a device or substance (including medications) to enable him/her to carry out the abilities required by the program? <b>Yes</b> _____ <b>No</b> _____ If yes, specify:

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Previous Vaccinations (not required)**

<p align="center"><b>HEPATITIS B STATUS</b></p> <p><b>Students who have received the vaccine series</b> will need proof of 3 Hepatitis B vaccines:          Dates: 1. _____ 2. _____ 3. _____</p> <p align="center"><b>OR</b></p> <p><b>Students who have not yet received the vaccine</b> will need to receive three doses of Hepatitis B vaccine and have a follow up titer 4-8 weeks after the third injection:  <b>Vaccine Dates:</b>          1. _____ 2. _____ 3. _____  <b>Titer Date:</b> _____ <b>Results:</b> _____</p> <p>Please provide a copy of titer results.          Immune Status: _____ Positive _____ Negative*</p> <p align="center"><b>OR</b></p> <p><b>*IF unable to detail dates received, a Hepatitis B surface antibody titer can be performed</b>          Date: _____ Results: _____          Please provide a copy of titer results.          Immune Status: _____ Positive _____ Negative*</p> <p><b>*IF TITER NEGATIVE:</b> Student will need documentation of 3 doses of Hepatitis B Vaccine.          Dates: 1. _____ 2. _____ 3. _____          Second dose should be minimum of 4 weeks after the first, third dose should be a minimum of 8 weeks after the second, and a minimum of 16 weeks after the first.</p> <p><b>If students are unable to get the Hepatitis B vaccines for medical reasons, they must sign a Non-Immunity Form</b> (available on CastleBranch website or from Program Director) <b>and have medical documentation from their healthcare provider.</b></p> <p><b>***Some clinical sites require Hepatitis B vaccination, signing a non-immunity form instead of getting the vaccination may affect the student's ability to attend clinical courses at those institutions.</b></p>	<p align="center"><b>Hepatitis A Vaccine</b></p> <p>Vaccination Dates:          Dates: 1. _____ 2. _____</p> <p align="center"><b>Pneumococcal Vaccine</b></p> <p>Vaccination Dates:          Dates: 1. _____ 2. _____</p> <p align="center"><b>Meningococcal Vaccine</b></p> <p>Vaccination Dates:          Dates: 1. _____ 2. _____</p> <p align="center"><b>Haemophilus Influenzae type B (Hib)</b></p> <p>Vaccination Dates:          Dates: 1. _____ 2. _____ 3. _____</p> <p align="center"><b>HPV Vaccine</b></p> <p>Vaccination Dates:          Dates: 1. _____ 2. _____</p> <p align="center"><b>COVID Vaccine</b></p> <p>Vaccine Manufacturer: _____</p> <p>Number of Injections in the Series: One _____ Two _____</p> <p>Vaccination Date/s:          Dates: 1. _____ 2. _____</p>
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\_\_\_\_\_  
Signature of Physician/ Nurse Practitioner/ Physician Assistant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

Address: \_\_\_\_\_

\_\_\_\_\_  
Phone Number: \_\_\_\_\_

## **STUDENTS IN NEED OF ACCOMMODATIONS:**

Students with disabilities who are in need of accommodations should contact the campus disability coordinator listed below. Coordinators for each campus are listed here: <http://www.hacc.edu/Students/DisabilityServices/Contact-Disability-Services.cfm>

## **EEOC POLICY 005:**

It is the policy of Harrisburg Area Community College, in full accordance with the law, not to discriminate in employment, student admissions, and student services on the basis of race, color, religion, age, political affiliation or belief, gender, national origin, ancestry, disability, place of birth, General Education Development Certification (GED), marital status, sexual orientation, gender identity or expression, veteran status, genetic history/information, or any legally protected classification. HACC recognizes its responsibility to promote the principles of equal opportunity for employment, student admissions, and student services taking active steps to recruit minorities and women.

The Pennsylvania Human Relations Act ("PHRAct") prohibits discrimination against prospective and current students because of race, color, sex, religious creed, ancestry, national origin, handicap or disability, record of a handicap or disability, perceived handicap or disability, relationship or association with an individual with a handicap or disability, use of a guide or support animal, and/or handling or training of support or guide animals.

The Pennsylvania Fair Educational Opportunities Act ("PFEOAct") prohibits discrimination against prospective and current students because of race, religion, color, ancestry, national origin, sex, handicap or disability, record of a handicap or disability, perceived handicap or disability, and a relationship or association with an individual with a handicap or disability.

Information about these laws may be obtained by visiting the Pennsylvania Human Relations Commission website at <http://www.phrc.pa.gov/Pages/default.aspx#.V2HOujFuNS0>.

## **FUNCTIONAL POSITION DESCRIPTION FOR THE ALS PROVIDER:**

### **QUALIFICATIONS:**

The following is a position description for the Advanced EMT, Paramedic, and Pennsylvania certification level of Prehospital R.N. (PHRN), Prehospital Physician Extender (PHPE) and Prehospital Physician (PHP), (hereafter referred to as an ALS Provider). This document identifies the qualifications, competencies and tasks expected of the ALS Provider.

### **COMPETENCIES:**

The ALS Provider must demonstrate competency in handling emergencies utilizing advanced and basic life support equipment in accordance with the objectives in the National Education Standards, or other objectives identified by the Department, to include having the ability to:

- Verbally communicate in person via telephone, telecommunications or with other form of electronic devices using the English language.
- Hear and interpret spoken information from co-workers, patients, families, other healthcare workers, physicians and dispatchers as well as sounds common to the emergency scene.
- Lift, carry and balance a minimum of 125 pounds equally distributed (250 pounds with assistance), a height of 33 inches, and a distance of 10 feet.
- Read and comprehend written/printed materials under stressful conditions.
- Verbally interview patients, family members and bystanders, other healthcare workers and be able to hear and interpret their responses.
- Document physically, in writing or via an electronic device, all relevant information in prescribed format.
- Demonstrate manual dexterity and fine motor skills, with the ability to perform all tasks related to quality patient care.
- Bend, stoop, crawl and walk on uneven surfaces.
- Meet minimum vision requirements to operate a motor vehicle within the state.
- Function in varied environmental conditions such as lit or darkened work areas, extreme heat, cold and moisture.
- Interpret written, oral and diagnostic forms of instruction.
- Perform in situations that create stress and tension on a regular basis