Health and Safety Requirements Worksheet

Name:____**Date**:____________________

Use this worksheet as a guide to ensure that you have documentation of each requirement. **DO NOT** upload this document into American DataBank or myClinicalExchange. Only supporting documents (lab results, immunization records, signed healthcare provider form, etc.) for each requirement should be uploaded.

Additional information regarding acceptable documentation for each requirement can be found on the American DataBank website. MCCCD requires all students to meet the placement requirements as set up by our program's most stringent clinical partner. We do this for ease of random placement.

⎦ **COVID-19 Vaccine:** To meet requirement:

1. Date of 1st injection __________ Date of 2nd injection __________

OR

2. Date of single-dose injection __________

OR

3. Provide a signed declination form for medical or religious reasons.

⎦ **MMR (Measles/Rubeola, Mumps and Rubella)** To meet requirement:

1. MMR vaccination: Dates: #1______________ #2____________

OR

2. Date & titer results:

Booster:______________
Measles:______________________________
Mumps:_______________________________
Rubella: ______________ _______________

⎦ **Varicella (Chickenpox)** To meet requirement:

1. Varicella vaccination dates: #1______________ #2____________

OR

2. Date & results of varicella IgG titer: Date: ________________ Result:________________, Booster:_________

⎦ **Tetanus/Diphtheria/Pertussis (Tdap)** To meet requirement: Tdap vaccine: Date: ___________________

Td booster: Date: _____________

⎦ **Tuberculosis** To meet requirement:

1. Negative 2-step TB Skin Test (TBST), including date of administration, date read, result, and name and signature of healthcare provider.

Initial Test (#1) Date:_____________ Date Read: _____________ Results: Negative or Positive Results:
Boosted Test (#2) Date: _____________ Date Read: _____________ Negative or Positive

2. Annual 1-step TBST (accepted only from continuing students who have submitted initial 2-step TBST)

Date: ____________ Date Read: _____________ Results: Negative or Positive

OR

3. Negative blood test (Either QuantiFERON or TSpot)

QuantiFERON Date: _____________
T-Spot Date:___________

OR

4. Negative chest X-ray

OR

Health and Safety Requirements Worksheet (continued)

Tuberculosis (continued)

5. Documentation of a negative chest X-ray (x-ray report) or negative QuantiFERON result and completed Tuberculosis Screening Questionnaire (available in American DataBank).

Date: ____________

⎦ **Hepatitis B** To meet requirement:

1. Positive HbsAb titer Date: ______________ Result: ____________

OR

1. Proof of 2 Hepatitis B vaccinations

Hepatitis B vaccine/dates: #1______________#2____________

OR

2.
3. Proof of 3 Hepatitis B vaccinations

Hepatitis B vaccine/dates: #1______________#2_____________ #3____________

OR

4. Hepatitis B declination- students who choose to decline Hepatitis B vaccine series must submit a HBV Vaccination Declination form.

⎦ **Flu Vaccine** To meet requirement:

Documentation of current annual flu vaccine Date: ________________

⎦ **CPR (Healthcare Provider or Equivalent) Certification** To meet requirement:

CPR card or certificate showing date card issued:________________Expiration date: ______________

⎦ **Level One Fingerprint Clearance Card (FCC)** To meet requirement:

Level One FCC including date card issued:________________Expiration date: ______________

⎦ **Health Care Provider Signature Form** To meet requirement:

Healthcare Provider Signature Form signed and dated by healthcare provider. Date of exam: ____________________

⎦ **Castle Branch Background Clearance Document** To meet requirement:

American DataBank background check document with date of "Pass" status: ______________________

Allied Health Student Health and Safety Documentation Checklist

Clearance for Participation in Clinical Practice

It is essential that allied health students be able to perform a number of physical activities in the clinical portion of their programs. At a minimum, students will be required to lift patients and/or equipment, 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 their assigned responsibilities. The clinical allied health 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. This declaration should not impede students with disabilities from applying or being accepted into the program.

I believe the applicant (print name):____Date: ______________

_______WILL OR_______WILL NOT be able to function as an allied health student as described above.

If not, explain: ____

____

____

Licensed Healthcare Provider (MD, DO, NP, or PA) Verification of Health and Safety

Print Name:_______________________________________Title: __________________________________

Signature:____Date: ________________________________

Address: ____

City:____State: ________________________________

Telephone: _______________________________________