



**FULL-TIME ADULT STUDENT**  
**Acceptance Package**  
**Phase II**

**THE FOLLOWING FORMS ARE NOT TO BE**  
**COMPLETED AND RETURNED UNLESS YOU**  
**ARE ACCEPTED INTO A PROGRAM**

# Connecticut Technical High School System

Student's Name \_\_\_\_\_ Student ID # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Student's Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Alt/email \_\_\_\_\_  
Emergency Contact Name \_\_\_\_\_ Phone (1) \_\_\_\_\_ (2) \_\_\_\_\_

- ( ) Aviation Maintenance Technician  
( ) Licensed Practical Nurse

## TO THE EXAMINING PHYSICIAN/HEALTHCARE PROVIDER:

Date of Exam: \_\_\_\_\_

On the basis of my health assessment and physical exam:

Student denies Latex Allergy

Student is clear to participate in clinical nursing courses with no restrictions (please check)  Yes  No

IF NO, please explain the nature of the restrictions/limitations related to the delivery of patient care:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## IMMUNIZATION ASSESSMENT

Please refer to the CDC *Healthcare Personnel Vaccination Recommendations* at <http://www.immunize.org/catg.d/p2017.pdf>

**TITERS MUST BE POSITIVE PER LABORATORY STANDARD; REPORT MUST ACCOMPANY THIS FORM. If titers show student is not immune, please state plan of how non-immunity will be addressed.**

RUBEOLA (MEASLES) TITER \_\_\_\_\_ Immune? Yes \_\_\_\_\_ No \_\_\_\_\_  
*May be Qualitative or Quantitative Titer* *Laboratory report must be attached*

*If No, include plan for or evidence of receipt of 2 doses of MMR Vaccine; refer to CDC guidelines*  
<http://www.immunize.org/catg.d/p2017.pdf>

RUBELLA (GERMAN MEASLES) TITER \_\_\_\_\_ Immune? Yes \_\_\_\_\_ No \_\_\_\_\_  
*May be Qualitative or Quantitative Titer* *Laboratory report must be attached*

*If No, include plan for or evidence of receipt of 2 doses of MMR Vaccine; refer to CDC guidelines*  
<http://www.immunize.org/catg.d/p2017.pdf>

MUMPS TITER \_\_\_\_\_ Immune? Yes \_\_\_\_\_ No \_\_\_\_\_  
*May be Qualitative or Quantitative Titer* *Laboratory report must be attached*

*If No, include plan for or evidence of receipt of 2 doses of MMR Vaccine; refer to CDC guidelines*  
<http://www.immunize.org/catg.d/p2017.pdf>

VARICELLA (CHICKEN POX) Provide Evidence of Immunity by:  Physician diagnosis **or**  Titer **or**  Lab confirmation of disease **or**  
 2 doses of varicella vaccine  $\geq$  28 days apart

*May be Qualitative or Quantitative Titer* *Laboratory or physician report of diagnosis must be attached*

TETANUS/DIPHTHERIA/PERTUSSIS (Tdap/Td) Date of Tdap/Tetanus/Td Booster \_\_\_\_\_ (date given must be within last 10yrs)

*All healthcare personnel (HCP), regardless of age, should receive a single dose of Tdap as soon as feasible if they have not previously received Tdap and regardless of the time since last Td dose; then they should receive Td boosters every 10 years thereafter. For further information see: <http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-td-tdap.pdf>*

**ANNUAL ASSESSMENTS/REQUIREMENTS:**

**Hep. B SERIES:** \_\_\_\_\_  
Per protocol      1<sup>st</sup> dose      2<sup>nd</sup> dose      3rd dose

*Student has been determined to be a non-responder and is aware of CDC recommendations for exposure to Hepatitis B surface antigen positive blood, refer to CDC guidelines <http://www.immunize.org/catg.d/p2017.pdf>*

Hep. B Surface Antibody Titer \_\_\_\_\_ Immune? Yes \_\_\_\_\_ No \_\_\_\_\_ (if no, revaccinate with add'l 3 dose series)  
**≥10mIU/ml is positive/Immune** (1-2 months following Dose #3)      **Laboratory report must be attached**

**TST** (Tuberculosis Skin Test required yearly)  
(TST must be performed in accordance with requirements of clinical facilities)      \_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_  
Date Given      Date Read      Results

**If previously positive TST (Year 2 and forward) complete Annual TB screening form:**  Student shows no evidence of TB symptoms

**If new positive TST provide:**  chest x-ray report showing no evidence of active TB disease      **Attach Official report(s)/record(s)**

**Influenza Vaccination** is required yearly; please provide evidence of vaccination per CDC protocol \_\_\_\_\_  
**Official report/record must be attached**      Date Given

\_\_\_\_\_  
**Healthcare Provider Print Name      Healthcare Provider Signature      DEA Number      DATE**

**Address:** \_\_\_\_\_ **Telephone** (      ) \_\_\_\_\_ - \_\_\_\_\_

# Connecticut Technical High School System

## Student Statement of Responsibility

I understand that I must submit a completed Health Assessment form prior to participation in any clinical experiences.

I am aware that if my health status should change in a way that would impact my ability to perform in the nursing program, I must notify the Director/Administrator of the program immediately. The need for additional clearance will be determined at that time.

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Student Name (Please Print)

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Student Signature

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Date

# Connecticut Technical High School System

## Annual Tuberculin Screening Form

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_

History of Positive Tuberculin Skin Test:  YES  NO

History of BCG Vaccine:  YES  NO

Date of last chest x-ray: \_\_\_\_\_ Results: \_\_\_\_\_

### **Current Symptom Assessment:**

Signs and symptoms of active TB:  YES  NO

If yes, indicate medical treatment plan:

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Student is cleared to attend clinical assignments with no restrictions:  YES  NO

\_\_\_\_\_  
Primary Care Provider (Print Name) \_\_\_\_\_  
Date

\_\_\_\_\_  
Primary Care Provider Signature \_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip Code

## Information for Students and Healthcare Providers about Immunity Assessment/Titers for Nursing Students

MMR: **the MMR titers once determined do not have to be rechecked, regardless of when drawn.** It is possible that they may be lowered during pregnancy, but otherwise should remain consistent. In this case a *qualitative* titer is acceptable. In a situation whereby a student was vaccinated in year one of the program, titers should be validated in year 2 of the program.

Varicella: *Quantitative* titers should be drawn once; **if immunity is determined to be present then student does not need titer drawn for second year.** In any case if student is immunized year 1 then titer should be drawn year 2, the key is QUANTITATIVE titer vs. qualitative (i.e. EIA index is not a quantitative titer).

Hepatitis B: Very Tricky. Some people NEVER develop immunity; some can lose immunity over time, thereby requiring a booster. So with this in mind: Those students that go through their series of injections during or in preparation for year one of the program, should then go on to have a QUANTITATIVE test for year 2. This value must exceed 10 milliunits / ml to establish immunity. If immunity is not established, the student should have a booster and have immunity rechecked.

**If a student produces a recent titer (less than 5 years old) that establishes immunity this will suffice for both years. In the event that a student produces a titer 5 years or older a quantitative titer is required for year 1.**

The student that comes to us stating they have had the series in the past, regardless of proof of the shots, still need to have a quantitative titer done to establish immunity. For all intents and purposes for any student (even those who are readmitted or transferred) this should suffice as long as we were within a 5 year window of time from the initial establishment of immunity. If a student refuses to receive Hepatitis B immunization a waiver must be signed and kept on file.

PPD: Must be updated on a yearly basis in order to maintain status in the program, exceptions:  
Students who have received BCG immunization should not get a PPD  
Students who have had a positive PPD  
Students who are immunosuppressed, have cancer, or are on steroids should not get a PPD

If PPD cannot be obtained because of the above, student should have a SINGLE chest x-ray to document freedom from disease. Thereafter, on a yearly basis, a note must be received from the Healthcare provider stating that the student shows no evidence of symptoms of TB.

Source: Quest Diagnostic Laboratory, July 2004

## **REFUSAL FOR USE OF HEPATITIS B VIRUS VACCINE**

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. However, I decline hepatitis B vaccination at this time. I understand that by declining this hepatitis B vaccination at this time, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can then receive the vaccination series.

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

DATE: \_\_\_\_\_





