

I give consent for PPCC NUA Program to share the results of the immunizations and physical questionnaire with clinical agencies as requested

(Student Signature)

(Date)



PIKES PEAK COMMUNITY COLLEGE

Pikes Peak Community College NUA Program Health and Immunization Record

Name Last First Middle

Date of Birth Mo Day YR Age PPCC S Number Last 4 of Social Security Number

Part A: Parts A & B TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. Enter all information in English.

I. REQUIRED FOR ALL STUDENTS.

Tetanus, Diphtheria & Pertussis (Tdap)-booster must be within the last ten years... Mo Yr

MMR (Measles, Mumps, Rubella) Two doses required, at least one month apart.....Dose #1 Mo Yr Dose#2 Mo Yr

OR ALL 3 OF THE FOLLOWING CRITERIA ARE MET:

MEASLES (RUBEOLA) Has report of positive immune titer. Specify date: Mo Yr

Or two doses of individual rubeola vaccine Dose #1 Mo Yr Dose #2 Mo Yr

RUBELLA (GERMAN MEASLES) Has report of positive immune titer. Specify date: Mo Yr

Or two doses of individual rubella vaccine Dose #1 Mo Yr Dose #2 Mo Yr

MUMPS Has report of positive immune titer. Specify date: Mo Yr

Or two doses of individual mumps vaccine Dose #1 Mo Yr Dose #2 Mo Yr

HEPATITIS B: Has report of positive immune titer. Specify date: Mo Yr

Or three doses of individual hepatitis vaccine Dose #1 Mo Yr Dose #2 Mo Yr Dose #3 Mo Yr

VARICELLA (chicken pox): Two doses one month apart recommended for adults with no history of disease: Has report of positive immune titer. Specify date: Mo Yr

or Dose #1 Mo Yr Dose #2 Mo Yr

I attest that I have examined the individual named above and to the best of my knowledge he/she is in good physical health and capable of performing the minimum technical standards outlined in the NUA course handbook.

Health Care Provider with Title: (Print name) (Signature) (Date)

Address and Phone number required

Continue on to Part B for Tuberculosis Screening and Influenza Vaccine (Required for all students)

PART B: Tuberculosis Screening and Influenza Vaccine

Name: _____ Date of Birth _____ S#: _____

1. Does the student have signs or symptoms of active TB disease? YES NO
If NO, proceed to 2.

If YES, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

PLEASE USE THE SPACE BELOW TO DOCUMENT TUBERCULIN SKIN TESTING AND/OR CHEST RADIOGRAPHY (Based on assessment criteria outlined above)

2. **A. Tuberculin Skin Test/PPD**

Date given:

Mo	Day	Yr

 Date read:

Mo	Day	Yr

 Results: _____ MM
(Record actual MM of indurations, transverse diameter; if no in duration, write "0")

Interpretation (based on MM of induration's as well as risk factors)
 Positive Negative

B. Chest X-Ray (required if tuberculin skin test is positive or if PPD has not been placed but patient is at risk of disease; must have been performed. Result: Normal Abnormal Date of chest x-ray: _____
INH Initiated Date _____ X _____ months

C. Quantiferon: Date of Test: _____ Positive (≥ 0.35 IU/mL) Negative

History of positive PPD and/or negative Quantiferon results requires annual TB screening with a Healthcare Provider:

- 1. Have you been having a bad cough that last longer than 2 weeks? YES NO
- 2. Have you been having pain in the chest? YES NO
- 3. Have you been coughing up blood or sputum (phlegm from deep inside the lungs)? YES NO
- 4. Have you experienced weakness or fatigue? YES NO
- 5. Have you experienced chills, fevers, or sweating at night? YES NO
- 6. Have you experienced weight loss or a loss of appetite? YES NO

INFLUENZA:

Date of last dose: ____/____/____
 M D YYYY

HEALTH CARE PROVIDER: (signature required as validation of correct information for immunizations and TB assessment)

Name and Title: _____ Address: _____

Signature: _____ Phone: _____ Date: _____