Health Sciences Student Health Form

Last Name	First Name	Middle Name	Date of Birth (month/day/year)

Part 1: Immunization Record, PPD and Titers: Please review student's health record and complete the following:

SECTION A - IMMUNIZATIONS

	Vaccination Date			
Tdap (must be within last 10 years)				
	MMR # (date)	MMR #2 (date)	Rubella Titer (IgG)	Rubeola Titer (IgG)
MMR (2 doses or titers with proof of immunity provided)			Immune	Immune
			No immunity	No immune
	Hep B #1(date)	Hep B #2(date)	Hep B #3 (date)	
Hepatitis B Series (Must have first in series before start of program)				
	Date Administered	Date Read	Result	Provider Signature
Tuberculin (PPD) Test				
Chest x-ray (if positive PPD)				
	Vaccination Date			
Influenza Vaccine (prior to clinicals, during timeframe of October 1st – March 31st)				

SECTION B – REQUIRED TITERS

	Titer Date	Titer Results (Circle One)
Varicella Antibody Titer (if not immune, vaccination not required at this time)		Immune / No immunity
Hepatitis C Antibody Titer (Current titer must be within 6 months of start of program)		Positive / Negative
Hepatitis B Antibody Titer (IgG) (Upon completion of Hepatitis B series)		Immune / No immunity

Part 2: Performance Ability:

1. Based on my assessment of this student's physical and emotional status he/she appears to be in good health and capable of performing the duties associated with their respective Health Sciences Program (Program Technical Standards attached)? □ **YES** □ **NO** (Please check one)
2. If you answered "NO" to the previous question, please document the condition(s) that will prevent this student from performing the duties of their respective Health Sciences Program. _____

_____

Must be completed by a licensed Physician (MD or DO), Physician Assistant or Nurse Practioner.

Provider Name: _____ Provider Phone#: _____

Provider Address: _____ Provider License #: _____

Provider Signature: _____ Date: _____

South Florida State College

EMS Program

Hepatitis B Vaccination and Titer Form

(This form to be used to document subsequent vaccinations & titer results)

Student Name: _____ Date of Birth: _____

1. Hepatitis B Vaccination Series:

Hep B #1 (date)	Hep B #2 (date)	Hep B #3 (date)

Provider Name (printed): _____ Provider License #: _____

Provider Address: _____ Provider Phone #: _____

Provider Signature: _____ Date: _____

2. Titer to be done at least 6 weeks after completing Hepatitis B vaccination series:

Required Titer	Titer Date	Titer Results	Immune	Not Immune
Hepatitis B Antibody Titer (IgG)				

Provider Name (printed): _____ Provider License #: _____

Provider Address: _____ Provider Phone #: _____

Provider Signature: _____ Date: _____

South Florida State College

EMS Department

Annual Tuberculosis Testing Form

(Required to submitted when PPD yearly update performed)

Student Name: _____ Date of Birth: _____

History of negative PPD: (yearly update required)

	Date Administered	Date Read	Result	Provider Signature
Tuberculin PPD Test				
Chest X-ray (if skin test positive)				

Provider Name (printed): _____ Provider License #: _____

Provider Address: _____ Provider Phone #: _____

Provider Signature: _____ Date: _____

South Florida State College

EMS Department

Annual Influenza Vaccination Form

(All students must receive vaccination before clinicals during the timeframe of October 1st – March 31st)

Student Name: _____ Date of Birth: _____

	Date Administered	Injection Site & Lot Number
Influenza Vaccine		

Provider Name (printed): _____ Provider License #: _____

Provider Address: _____ Provider Phone #: _____

Provider Signature: _____ Date: _____

** Have provider fill in the above information and sign or attach proof of immunization from provider **