

**Norwalk Community College  
188 Richards Ave.  
Norwalk, CT 06854**

**HEALTH ASSESSMENT FORM  
for  
Non-Credit Allied Health Students participating in Clinical Activities**

**COMPLETED FORM IS DUE ON OR BEFORE**

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**PLEASE MAIL OR HAND DELIVER COMPLETED FORM TO:**

**Your Primary Instructor**

***Division of Nursing & Allied Health  
Norwalk Community College  
188 Richards Ave.  
Norwalk, CT 06854***



**Norwalk Community College  
Non-Credit Allied Health Programs**

**Addendum to HEALTH ASSESSMENT FORM  
for**

**Students participating in Clinical Activities with Positive PPD and Negative Chest x-ray**

**Student Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Survey questionnaire – To be completed by student if PPD is positive**

Have you experienced any of the following in the past year:

1. Night sweats? Yes\_\_\_\_\_ No\_\_\_\_\_

2. Persistent low grade fever? Yes\_\_\_\_\_ No\_\_\_\_\_

3. Cough that has lasted more than 1 month? Yes\_\_\_\_\_ No\_\_\_\_\_

4. Unexplained weight loss? Yes\_\_\_\_\_ No\_\_\_\_\_

5. Fatigue Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, to what do you attribute this? \_\_\_\_\_

6. Have you had any other symptoms? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please describe \_\_\_\_\_

7. Have you lived or visited abroad in the past year? Yes\_\_\_\_\_ No\_\_\_\_\_

8. Have you been in contact with anyone who has had TB? Yes\_\_\_ No\_\_\_\_\_

Student Signature\_\_\_\_\_

**Student shows no evidence of TB symptoms**

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

\_\_\_\_\_  
**Address**

(      ) \_\_\_\_\_ - \_\_\_\_\_  
**Telephone**

# Norwalk Community College Non-Credit Allied Health Programs

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

Refer to the CDC Healthcare Personnel Vaccination Recommendations [www.immunize.org/catg.d/p2017.pdf](http://www.immunize.org/catg.d/p2017.pdf)

**Tetanus/Diphtheria/Pertussis (Td/Tdap):** All adults who have completed a primary series of a tetanus/diphtheria-containing product (DTP, DTaP, DT, Td) should receive Td boosters every 10 yrs. For adults younger than 65 yrs, a 1-time Tdap is recommended to replace the next Td.

**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 with 2 doses of MMR vaccine within the past 12 months, no other documentation is necessary.

**Varicella: *Qualitative or Quantitative*** titers should be drawn once; if immunity is determined to be present then student does not need titer drawn for subsequent years. In a situation whereby a student was vaccinated with 2 doses of Varicella vaccine within the past 12 months, no other documentation is necessary.

**Hepatitis B:** 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 (Nichols number is: 51938P, apparently a classification system for labs). 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 at least two years. In the event that a student produces a titer 5 years or older a quantitative titer is required for year 1.
- If a student produces documentation of completion of the Hep B series according to proper immunization schedule, (2<sup>nd</sup> dose in 30 days, and 3<sup>rd</sup> dose in 180 days), given 5 years ago or older; dates of immunization are considered sufficient.
- If a student refuses to receive immunization for Hepatitis B despite counseling in favor of it, a waiver must be signed and kept on file.

**PPD:** The general standard for the majority of affiliates is a “one step” ppd. On occasion, clinical affiliates require a “two step” ppd, thus students affiliating at this facility must then be in compliance. It is felt at this time that this requirement is not widespread enough to make it the standard. All ppds 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

**Influenza Vaccination:** all healthcare workers should receive annual influenza vaccination *Trivalent (Inactivated) Influenza Vaccine (TIV)* may be given to anyone; *Live, Attenuated Influenza Vaccine (LAIV)* may be given to non-pregnant healthy persons age 49 years and younger (CDC, 2008). Exceptions made only for those students for whom their HCP states the vaccination is medically contraindicated.

References: Center For Disease Control <http://www.immunize.org/catg.d/p2017.pdf>,  
[http://www.nfid.org/influenza/professionals\\_workersflu.html](http://www.nfid.org/influenza/professionals_workersflu.html), <http://www.nfid.org/HCWtoolkit/>,  
<http://www.nfid.org/HCWtoolkit/CSLToolkitDocument.pdf>; Quest Diagnostic Laboratory, 2004

**Norwalk Community College  
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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.

\_\_\_\_\_  
Student Name (Please Print)

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date