DMACC
DES MOINES AREA COMMUNITY COLLEGE

HEALTH AND PUBLIC SERVICES DEPARTMENT
STUDENT HEALTH AND IMMUNIZATION RECORD

Program in which you are enrolling: ______________________ Campus: ______________

All students enrolling in the health and early childhood programs must complete Part I of this form before consulting with a health care provider (MD/DO, PA, NP) to verify dates of immunizations and treatment of current or chronic conditions. With the exception of immunization information or in the case of medical emergencies, no information will be released to anyone other than the Health and Public Service Department without consent of the student.

Program continuation requires each student to perform every essential function of the student role. If the student, with reasonable accommodation, is unable to perform any essential function in a safe and successful manner, they will be required to withdraw from the program.

PART I: BACKGROUND INFORMATION **To be completed by student. *(Please Print)***

A. **PERSONAL DATA** Gender: ☐ Male ☐ Female DMACC ID Number: 900______________

Last Name First Name Middle Initial Date of Birth

Home Address (Number and Street) City State Zip Code

Telephone: Home Work Health Insurance Company/Policy Number

( ) ( )
In Case of Emergency, Notify: Name Relationship Home Phone Work Phone

B. **PERSONAL HEALTH HISTORY**

DATE OF MOST RECENT
DENTAL EXAM ______________
month year

ALLERGIES: If none, write below None Known

Medication: ______________________________

Other Types: ______________________________

I have the following "Med-alert" condition: ______________________________

OTHER COMMENTS:

______________________ ______________________
Student Signature Date

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• Part II Medical History & Part III Immunizations **TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER**

PART II: **MEDICAL HISTORY** **Student Name** ______________________________________

1. **Physical/mental conditions which have required treatment within the last 6 months or are chronic in nature:**

2. **Medications taken currently or routinely:**

3. **Conditions which restrict activity and/or require special adaptation(s):**

4. Other:

5. **Core Performance Standards**:
Please refer to the attached **Iowa Core Performance Standards for Health Career Programs** and indicate if the above named individual may have difficulty meeting any of the eleven standards outlined.

At this time this individual is capable of meeting the performance standards:

____ **Agree**

____ **Disagree. The following limitations are present**____

____ **Additional evaluation suggested** ____

6. **Date of Last Physical Exam:** _______________
(within one year of program entry) mm/dd/yr

_____________ ____
Date **Signature of Health Care Provider (MD, DO, ARNP, PA)**

Iowa Core Performance Standards for Health Care Career Programs

Iowa Community Colleges have developed the following Core Performance Standards for all applicants to Health Care Career Programs. These standards are based upon required abilities that are compatible with effective performance in health care careers. Applicants unable to meet the Core Performance Standards are responsible for discussing the possibility of reasonable accommodations with the designated institutional office. Before final admission into a health career program, applicants are responsible for providing medical and other documentation related to any disability and the appropriate accommodations needed to meet the Core Performance Standards. These materials must be submitted in accordance with the institution's ADA policy.

Capability	Standard	Some Examples of Necessary Activities (Not All Inclusive)
Cognitive-Perception	The ability to perceive events realistically, to think clearly and rationally, and to function appropriately in routine and stressful situations.	• Identify changes in patient/client health status • Handle multiple priorities in stressful situations
Critical Thinking	Critical thinking ability sufficient for sound clinical judgment situations	• Identify cause-effect relationships in clinical • Develop plans of care
Interpersonal	Interpersonal abilities sufficient to interact appropriately with individuals, families, and groups from a variety of social, emotional, cultural, and intellectual backgrounds	• Establish rapport with patients/clients and colleagues • Demonstrate high degree of patience • Manage a variety of patient/client expressions (anger, fear, hostility) in a calm manner
Communication	Communication abilities in English sufficient for appropriate interaction with others in verbal and written form.	• Read, understand, write, and speak English competently • Explain treatment procedures • Initiate health teaching • Document patient/client responses • Validate responses/messages with others
Mobility	Ambulatory capability to sufficiently maintain a center of gravity when met with an opposing force as in lifting, supporting, and/or transferring a patient/client.	• The ability to propel wheelchairs, stretchers, etc., alone or with assistance as available
Motor Skills	Gross and fine motor abilities sufficient to provide safe and effective care and documentation.	• Position patients/clients • Reach, manipulate, and operate equipment, instruments, and supplies • Electronic documentation/keyboarding • Lift, carry, push, and pull • Perform CPR
Hearing	Auditory ability sufficient to monitor and assess, or document health needs.	• Hears monitor alarms, emergency signals, auscultatory sounds, cries for help • Hears telephone interactions/dictation
Visual	Visual ability sufficient for observation and assessment necessary in patient/client care, accurate color discrimination.	• Observes patient/client responses • Discriminates color changes • Accurately reads measurement on patient/client related equipment
Tactile	Tactile ability sufficient for physical assessment, inclusive of size, shape, temperature, and texture.	• Performs palpation • Performs functions of physical examination and/or those related to therapeutic intervention, e.g., insertion of a catheter
Activity Tolerance	The ability to tolerate lengthy periods of physical activity.	• Move quickly and/or continuously • Tolerate long periods of standing and/or sitting
Environmental	Ability to tolerate environmental stressors	• Adapt to rotating shifts • Work with chemicals and detergents • Tolerate exposure to fumes and odors • Work in areas that are close and crowded • Work in areas of potential physical violence

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Part III

Name________________________________ DMACC ID _________________ Due date: ______

Required Test and/or Immunizations

This form is to be completed, signed and dated by a licensed health care provider (MD, DO, ARNP, PA). Take your immunization records and documentation of disease with you to your appointment. If immunization records are not available, the HCP will determine what vaccinations tests or titers are indicated. **Documentation of the items below are required by the clinical agencies DMACC contracts with for clinical experience.**

TB 2-step Skin Test OR blood assay for TB Skin test must be PPD by Mantoux (NOT Tine) **within the last 12 months** prior to starting program. Annual testing is required.	Date Admin mm/dd/yy	Date Read mm/dd/yy	Results: mm of induration	If Positive PPD, Chest X-ray mm/dd/yy	If Positive PPD, Chest X-ray CXR Results	Is treatment plan indicated? Check one	**Blood Assay for *M.tb***
#1 skin test						☐ Yes-attach ☐ No	Name:
#2 skin test – must be more than 7 days but less than 1 year between #1 & #2.							Result:

Adult Diphtheria/Tetanus/Pertussis All healthcare personnel (HCP) who have not or are unsure if they have previously received a dose of **Tdap** should receive a one-time dose of Tdap as soon as feasible, without regard to the interval since the previous dose of Td. Then, they should receive Td boosters every 10 years thereafter. HCP Vaccination Recommendations Centers for Disease Control and Prevention, March 2011.	**Date of Tdap** mm/dd/yy Once in a lifetime booster required for Pertussis protection

Varicella (Chicken Pox) Evidence of Immunity includes any one of the following: • Positive titer • Two doses of vaccine • Documentation by HCP of chickenpox or herpes zoster. **Verbal history is not acceptable**	Must attach copy of Lab results Titer Date mm/dd/yy	Must attach copy of Lab results Titer Results	**Vaccination #1** Date mm/dd/yy	**Vaccination #2** Date mm/dd/yy	Documentation of HCP diagnosed varicella or herpes zoster. **Must attach document** Date of disease mm/dd/yy
					Must attach a separate document signed by health care provider who diagnosed disease. Include mm/dd/yy of diagnosis.

		First dose must be documented prior to submission of this health record and written verification of additional doses submitted as received.		
Hepatitis B **Evidence of immunity is mandatory for all* Health students and includes either** • **Completion of series, OR** • **Positive Titer of HBsAb** *Aging Services Management -Exempt	**Titer HBsAb:** Results/Date Must attach copy of Lab results	**Date Dose #1** Required prior to sub-mitting this record	**Date Dose #2** **(1-2 months)** mm/dd/yy	**Date Dose #3** **(4-6 months)** mm/dd/yy
	Must attach A copy of Lab results			

MMR All students (regardless of age) must have documentation of either 2 MMR vaccinations **OR** Documentation of sufficient titers for Rubeola, Mumps and Rubella. Those who have an "indeterminate" or "equivocal" level of immunity upon testing should be considered non-immune. **Lab results of titers must be attached to this form.**	**Titers**	**Titer date** mm/dd/yy	Titer results Must attach copy of Lab results	If born 1957 or later, 2 doses of live measles and mumps vaccines given on or after the first birthday, separated by 28 days or more. **Date MMR #1** mm/dd/yy	**Date MMR #2** mm/dd/yy
	Rubeola IgG		**Must attach copy of Lab results**		
	Mumps IgG		**Must attach copy of Lab results**		
	Rubella IgG		**Must attach copy of Lab results**		

Influenza Vaccine - Must attach documentation/receipt **Must attach a separate document signed by health care provider if the flu vaccine is contraindicated and reason for it.**	**Date of flu vaccine** mm/dd/yy	**Applies to current flu season** indicate year

I certify this student has received the TB test and immunizations as indicated above or has laboratory evidence of immunity which is attached to this form.

____ ____Date: ____________

Print Name of Health Care Provider **Signature of Health Care Provider (MD, DO, ARNP, PA)**

____ (_____)__________________

Address of Health Care Provider **City** **State** **Zip** **Phone**