INSTITUTE FOR CORPORATE & CONTINUING EDUCATION
YOUR LEADER FOR CUSTOMIZED WORKFORCE SOLUTIONS

Hillsborough Community College Corporate College
Collaboration Studio
1602 N. 15th St
Tampa, FL 33605

Student Health and Immunizations Certification
Health Science Programs (Page 1 of 2)

Dear Health Examiner:

Please provide your assessment of the following student's physical and mental ability to perform the "Essential Functions and Standards for Clinical Courses" indicated below. Mandatory to any clinical rotation, students entering Health Science programs also require documented proof of immunizations and health screening for communicable diseases. Proof includes completion of page 2 of this form by the student and verified, reviewed and signed by a licensed health care professional.

Student's Name: _____ Student's ID#:_____

Date of Birth (month/day/year): _____ Gender: male ___ female___

Address:_____ City, State, Zip:_____

Program Entered:_____

Essential Functions and Standards for Clinical Courses	
Environmental Conditions:	**Clinical Tasks and Skills:**
Potential exposure to bloodborne pathogens	Fine motor manipulation of hands and fingers
Potential exposure to infectious pathogens	Fitting/use of personal protective equipment
Work with latex, chemicals, water and detergents	Use latex protective gloves and N-95 Respirator mask
Work alone or in groups	Work irregular hours or work different shifts
Physical Requirements:	**Sensory and Cognitive Requirements:**
Ability to carry, lift, push, and pull 50-75 pounds	Binocular vision. Note if monocular
Gross motor skill to manipulate equipment	Near and far vision, uncorrected and corrected
Assist in transferring and lifting patients	Vision required 20/20 OU; Snellen may be used
Frequent reaching, grabbing and grasping	Screen for color deficiency
Seated and standing work, ranging minutes to hours	Ability to hear; whisper test at 12 feet. Note if aid needed
Frequent twisting, bending, and reaching overhead	Ability for multi-tasking
Occasional climbing to heights less than six (6) feet	Ability to communicate by speech clearly
Occasional stooping and kneeling	Ability for analytical thinking, reasoning, make calculations
Frequent trunk rotation	Ability to function in high stress, complex situations

Examiner Comments and Opinions (Please check one):

☐ In my opinion, **the student meets** the essential physical and mental standards noted above for participation in a clinical health care setting.

☐ In my opinion, **the student will require the following accommodations** or restrictions (e.g., corrective lenses) to participate without harm to self/others in a clinical health care setting:

_____

_____

☐ In my opinion, based on the following comments, **the student does not meet** the essential physical and mental standards noted above and is not able to participate without harm to self/others in a clinical health care setting:

_____

_____

_____

Examiner's Name:	Date:
Examiner's Signature:	License No.:
Address:	State/Zip:
Phone:	Fax:

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Student's Name: _____ **Student's ID#:** _____

MMR Titers may be done in lieu of vaccination documentation. Note: MMR may be given instead of individual immunizations. Please attach all copies of laboratory tests to this form when titers are performed.

Rubeola (Measles):	Two doses of live measles vaccine administered after 1967 with the first vaccination on or after the first birthday. The two doses must be at least 30 days apart.	
1st Immunization Date:	2nd Immunization Date:	Titer Result:
Rubella (German Measles):	One dose administered on or after first birthday.	
Immunization Date:	Titer Result:	
Mumps:	One dose administered on or after first birthday.	
Immunization Date:	Titer Result:	
Tdap:	**Date Given** (*must be within the past 10 years*):	
Tuberculosis Screening:	PPD (Mantoux) Test is required, not a Tine Test.	Must be read within 48-72 hours.
Date Administered:	Site Administered:	○ Left Arm ○ Right Arm
Date Read:	Result (in mm.):	
Name of Reader:	License No.:	
If positive PPD (> 10 mm) induration, any symptoms of Tb or known exposures?	○ Yes	○ No
Was prophylaxis medication (INH) taken?	○ Yes ○ No	Note: If history of + Tb, CXR needed within one (1) year.
Date of Chest X-Ray:	Chest X-Ray Result:	
Prior history of BCG? ○ No ○ Yes	Date:	PPD recommended unless BCG given within last two (2) years
Polio:	Was a primary childhood series completed? ○ Yes ○ No	Year last booster was given:
Hepatitis B:	Series of three (3) immunizations required, strongly recommended for health care workers.	
Second dose is to be given one (1) month after first dose. Third dose is to be given at least five (5) months after second dose. If student declines series, submit a completed declination form to the student's Health Science Program Manager.		
1st Immunization Date:	2nd Immunization Date:	3rd Immunization Date:
Hepatitis B Immune Titer (HHS antibody):	Test Date:	Result: ○ Positive ○ Negative
Varicella Titer (Chicken Pox):	Test Date:	Titer Result (actual level):
If titer is non-immune, two (2) doses of varivax vaccine are required.		
1st Varicella Vaccine Date:	2nd Varicella Vaccine Date:	

I hereby certify that I have reviewed this vaccination/immunization form and performed the required testing.	
Name:	Date:
Signature	License No.:
Address:	Telephone: