MASSBAY COMMUNITY COLLEGE
HEALTH SCIENCES PROGRAMS
PHYSICAL EXAM & IMMUNIZATION FORM

STUDENT INFORMATION **HEALTH SCIENCES PROGRAM:** _____

Last Name First M.I. MassBay Student ID #

Email Address Telephone Number Date of Birth

Student Signature (By signing this, I give permission for MassBay CC to release my Immunization information to clinical agencies) Date

PHYSICAL EXAMINATION
TO BE COMPLETED BY A PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT

ALL information requested on this form must be satisfactorily completed and received by program deadline date. This information is solely for the use by College staff and will not be released without the student's permission. Clinical sites will be notified that the student has met all the medical and immunization requirements. **Physical Exam must be within one year of program start date. All health information must be received, validated and approved on or prior to the program's due date.**

Date of Physical Exam: _____

MD signature: _____ **OR** NP or PA signature: _____

Print name: _____ Print name: _____

Address: _____ Address: _____

ESTIMATE OF THE APPLICANT'S HEALTH STATUS: **EXCELLENT** ☐ **GOOD** ☐ **POOR** ☐

Based on the above physical examination, I believe the student is mentally and physically able to perform the role of the health program the student is enrolled. Healthcare Program Technical Standards can be found in the Division of Health Sciences Student Handbook and Policy Manual.

Instructions for HCPs completing this form: Documentation of immunity to each of the following diseases is REQUIRED. Your signature and credentials are requested at the end of this form.

REQUIRED TESTING, IMMUNIZATIONS AND TITERS FOR HEALTH SCIENCES STUDENTS

Disease Immunity: (Please read carefully) Documented proof of immunity is required for the **ALL** communicable diseases listed in the tables below.

Tetanus & Diphtheria (Td) or Tetanus/Diphtheria/acellular Pertussis (Tdap) within the last 10 years	**Date Administered**	**Influenza Vaccine (for upcoming or current season during which you will be enrolled) Date Administered:**
One dose of Tdap received any time at or after 7 years of age.		
If it has been more than 7 years since Tdap was given, a dose of Td		

Student Name: _____

Tuberculosis Screening

MassBay Health Sciences program students are required to receive baseline TB screening within the past twelve months and an annual update thereafter. This can be accomplished in one of these three methods:

Tuberculin Skin Test (TST 2-Step): Two negative TB Skin (PPD) tests between 1 and 3 weeks apart. A single (1-step) TB implant is required annually thereafter. Students who have had a negative 2-step TB test in the past must provide that documentation below plus annual updates thereafter.

Interferon-Gamma Release Assays (IGRAs) - QuantiFERON® or T–Spot® are acceptable IGRA tests to satisfy the MassBay requirement. This is updated annually thereafter.

Chest X-ray - Submit verification of a chest x-ray (only acceptable if taken as a follow-up to a previous positive TST). The x-ray must be no older than 5 years. A negative symptom review check is also required if chest x-ray is older than 1 year and annually thereafter.

EMT students are required to have a single TB test or IGRA blood test with annual update or Chest X-Ray with annual negative symptom Review Check. 2-Step screening is not required.

Tuberculosis Testing	Date Administered	Date Read	Result
Step #1 (TST #1) and			
Step #2 (TST #2) one to three weeks later OR			
Single TST Annual update(s)			
QuantiFERON® or T–Spot®			
Chest X-ray-after positive TST result			
Negative Symptom Review Check			

Immunizations (Vaccine OR Titer)	Vaccine: Doses 1 and 2	Antibody Titer Result (indicate Laboratory numbers and positive or negative)
MMR	____/____/____ Mo Date Year ____/____/____ Mo Date Year	____/____/____ Mo Day Year Titer result: (pos. or neg.): _____ Laboratory Value: _____
Varicella	____/____/____ Mo Date Year ____/____/____ Mo Date Year	____/____/____ Mo Day Year Titer result: (pos. or neg.): _____ Laboratory Value: _____
Associate Degree Nursing and Practical Nursing Students ONLY: **Other Health Sciences students who are 21 years and younger and attending MassBay full time should provide this documentation to the Office of Student Development**		
Meningococcal: **Students 21 and younger: 1 Dose MenACWY administered after age 16 or signed waiver**	____/____/____ Mo Date Year	

Student Name: _____

Hepatitis B

EMT, Computed Tomography, and Radiologic Technology Students:
Students may submit EITHER three doses of the Hepatitis B vaccine/2 doses of the Heplisav OR a POSITIVE Hepatitis B antibody titer result.

Associate Degree Nursing, Central Processing Technology, Paramedicine, Phlebotomy, Practical Nursing and Surgical Technology Students:
Students MUST report three doses of Hepatitis vaccine and a POSITIVE Hepatitis B surface antibody titer result OR a POSITIVE Hepatitis B surface antibody titer. If the antibody titer is negative, indeterminate, or equivocal, the student must repeat the Hepatitis B Series and repeat the Hepatitis B antibody titer. A negative antibody titer will only be accepted if it is following the documented initial Hepatitis B vaccine series and is followed by the start of the 2nd series. If the second antibody titer is negative, the student will be considered a non-responder to the vaccine. In this case, the student should submit a letter from the healthcare provider.

Hepatitis B (all information must be provided)	**Yes/No**	**Date of 1st injection**	**Date of 2nd injection**	**Date of 3rd injection**	**Titer Result (indicate value, positive or negative) and Date**
Hepatitis B Initial Series					
Repeat Hepatitis B series and titer if first antibody titer is negative					
Letter from healthcare provider stating student will not convert after two complete Hepatitis B series (please attach)					

COVID-19 Vaccination (Required for All Health Sciences Students)

Provide name of manufacturer, Lot #, dates of the initial vaccine: two doses of the COVID vaccine (Moderna or Pfizer-BioNTech) or one dose (Johnson and Johnson's Janssen) and the name of manufacturer, date, and lot # of a booster dose. Note: students may be still be required to bring their COVID Vaccine card with them to clinical assignments or submit COVID vaccine card to MassBay Community College.

COVID VACCINE	**Dose #1 – date and lot#**	**Dose #2 – date and lot #**	**Dose #3/Booster – Date and lot #**
Manufacturer Name:			
Booster Dose Manufacturer Name:			

MD, NP, or PA Signature_____Date_____

Rev.03/23/2022