



# Wisconsin Indianhead Technical College Nursing and Allied Health Division Health Form

**Student Name:** \_\_\_\_\_ **Student ID:** \_\_\_\_\_

## Please check appropriate program:

- Dental Assistant** (due the first day of Dental Health and Safety)
- Health Information Technology** (due at the start of Professional Practice 1)
- Medical Assistant** (due at the start of 1<sup>st</sup> semester core classes)
- Nursing-Associate Degree** (due \_\_\_\_\_)
- Occupational Therapy Assistant** (due 1st day of Activity Analysis and Applications/1<sup>st</sup> semester)
- Pharmacy Technician** (due \_\_\_\_\_)
- Phlebotomy** (due \_\_\_\_\_)

## Instructions:

1. This form must be filled out within 90 days of the day it is due. The physical examination must be completed within the past year.
2. Fill out pages 2-3 of the form. Then take the form with you to your physical examination.
3. **Official** documentation is **required** for proof of history of infectious diseases or immunizations. Attach official health records documenting infectious diseases or immunizations to this form.

4. If you require accommodations as defined by the American Disabilities Act, work directly with the WITC campus Accommodation Specialist and your instructor **prior to beginning coursework.**
5. Sign the release of information at the end of the form.
6. Before submitting the health form to your instructor or academic advisor or uploading it to CastleBranch or Student Passport, **make a copy** of the completed form for your records.



**WISCONSIN INDIANHEAD TECHNICAL COLLEGE  
NURSING and ALLIED HEALTH DIVISION HEALTH FORM**

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Legal Name: Last First Middle

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Date of Birth (MM/DD/YY) Gender: Male or Female

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Current address

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City State Zip Code

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Primary phone number Cell number

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E-mail Address

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In case of emergency contact: Name (First and Last) Relationship to Person

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Address Telephone Number

**MEDICATIONS and PAST MEDICAL HISTORY: TO BE COMPLETED BY THE STUDENT**

|  |                           |
|--|---------------------------|
| <p>1. Allergies: (Medication or Agent):</p><br><br><br><p>2. Is an EpiPen prescribed?</p><br><br><br><p>3. Any reactions to latex/silicone?</p>  | <p>Describe Reaction:</p> |
| <p>Chronic diseases:</p><br><br><br><p>Major illnesses, hospitalizations, operations, and/or injuries in the past year:</p><br><br><br><p>Describe any back injuries or chronic back pain.</p> |                           |
| <p>List all current medications:</p><br><p>1. Prescription</p><br><br><br><p>2. Non-prescription</p>   |                           |

**PHYSICAL EXAMINATION: TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT**

|                             | NL | ABNL | Please describe any abnormalities. Use second sheet if necessary |
|-----------------------------|----|------|--|
| General                     |    |      |  |
| Skin                        |    |      |  |
| Head/Eyes/Ears/Nose/Mouth   |    |      |  |
| Neck and Thyroid            |    |      |  |
| Lungs/Chest                 |    |      |  |
| Breasts                     |    |      |  |
| Heart                       |    |      |  |
| Abdomen                     |    |      |  |
| Genitalia                   |    |      |  |
| Back/Spine                  |    |      |  |
| Extremities/Musculoskeletal |    |      |  |
| Neurologic                  |    |      |  |
| Emotional/Psychological     |    |      |  |

- A. Describe any abnormalities, limitations and regularly-used medications which may have an impact on performance in a health agency setting.
  
- B. Describe degree of control of any chronic conditions.
  
- C. Are there any lifting restrictions for this student? If so, specify.
  
- D. Are there any other restrictions for this student? If so, specify.
  
- E. Is this student free from communicable diseases?

I have reviewed the medical history and immunization record and have examined the student. The information is accurate.

MD/NP/PA Signature \_\_\_\_\_ Date \_\_\_\_\_

Provider Name (Please print) \_\_\_\_\_

Clinic Name: \_\_\_\_\_

## INFECTIOUS DISEASES AND IMMUNIZATIONS

Official health records documenting these infectious diseases and/or immunizations ***must accompany this form.***

| Disease                          | Required Documentation  |
|----------------------------------|---|
| Measles & Mumps                  | Lab evidence of immunity <u>OR</u><br>2 doses of MMR after 1 <sup>st</sup> birthday. The 2 doses must be at least 28 days apart.  |
| Rubella                          | Lab evidence of immunity <u>OR</u><br>1 dose of MMR after 1 <sup>st</sup> birthday  |
| Tetanus, Diphtheria, & Pertussis | 1 dose of Tdap<br><br>Those who never received a Tdap vaccine should receive the vaccine regardless of time since the last Td vaccine.<br><br>Tdap immunization lasts for 10 years. Td boosters should be given every 10 years after Tdap immunization.<br><br>The CDC recommends that pregnant women receive a dose of Tdap during each pregnancy.   |
| Varicella (Chickenpox)           | Lab evidence of immunity <u>OR</u><br>2 doses of Varicella vaccine after 1 <sup>st</sup> birthday. The 2 doses must be at least 28 days apart.  |
| Influenza                        | Annual influenza vaccine <b>is required for Nursing-Associate Degree and all Allied Health</b> programs. The vaccine should be obtained before November 1 for fall semester clinical or prior to spring semester clinical. Students in clinical placements between April 1 <sup>st</sup> and October 1 <sup>st</sup> are exempt from influenza requirement.   |
| Hepatitis B                      | Lab evidence of antibodies <u>OR</u><br>evidence of the start of the immunization series.<br><br><ul style="list-style-type: none"> <li>• <b>ADN, OTA, and HIT students</b> may begin clinicals after starting the Hepatitis B series.</li> <li>• <b>MA students</b> need to have had at least 2 of the immunizations before the start of practicum.</li> </ul> <p>Students should complete the Hepatitis B series. It is recommended that students receive a titer 1-2 months after completing the series.</p> |

## Tuberculosis

### The Mantoux test comes as a 1-step or 2-step process:

- **1-step test** consists of an injection with a follow-up reading of the injection site within 48-72 hours.
- **2-step test** consists of an injection with a follow-up reading of the injection site within 48-72 hours, followed by a **second** injection and reading within 1-3 weeks of the first injection.

### When do you need a 1-step?

- You have documented proof that you have had a 2-step **within one year** and want to renew your Mantoux test.

### When do you need a 2-step?

- You have never had a 2-step Mantoux test.
- It has been **over one year** since your last 2-step.

### Where can I get my Mantoux test?

This test may be available to WITC students through WITC Health Services during normal office hours. You can also receive this test at your local clinic.

Documentation of the most current TB skin test or IGRA blood test (QFT-GIT or T-Spot). This should be done **within 90 days** of the start of clinicals.

For students in programs over one year in length, TB skin test should be done annually.

If the most current TB test is the student's first TB test, or if the most current TB test was over 12 months ago, a 2-step TB skin test\* or IGRA is required.

If the TB skin test or IGRA is positive, the following is required:

- Negative chest x-ray dated after positive TB skin test conversion.
- Written verification from a healthcare provider that the student is free of TB symptoms and is not communicable.
- Annual health symptom TB questionnaire.

### \*What is the 2-step TB test?

In some persons who are infected with TB, the ability to react to TB tests may wane over time. When given a TB test years after infection, these persons may have a false-negative reaction. However, the TB test may stimulate the immune system causing a positive or boosted reaction to subsequent tests. Giving a second TB test after an initial negative TB reaction is called 2-step testing. The 2<sup>nd</sup> test is usually done 1-3 weeks after the 1<sup>st</sup> test.

2-step testing is often done for healthcare workers who will be retested periodically. It can reduce the likelihood that a boosted reaction to a subsequent TB test will be misinterpreted as a recent infection.



**WISCONSIN  
INDIANHEAD  
TECHNICAL  
COLLEGE**

**Annual TB Questionnaire  
WITC Nursing-Associate Degree and Allied Health Programs**

WITC Nursing-Associate Degree and Allied Health students with a positive TB skin test or IGRA must submit this TB questionnaire annually.

Name \_\_\_\_\_

Date \_\_\_\_\_

Date of last Chest X-Ray \_\_\_\_\_

**Do you currently have any of the following symptoms?**

**Check Yes or No**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Persistent cough (greater than 3 weeks duration) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Unexplained weight loss                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Fever  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Night sweats                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Loss of appetite                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Coughing up blood                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Shortness of breath                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Fatigue or weakness                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Chest pain                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Hoarseness                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |



I certify that all information is correct. I understand that it is my responsibility to report any changes in my health status to my WITC Program Director.

I authorize WITC to release my immunization record, which is attached to this form, to a clinical agency/agencies that require it for my participation in a clinical course.

Please Print Name \_\_\_\_\_

Student ID \_\_\_\_\_

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