MEDICAL REQUIREMENTS
For ALL PN and RN Program Students

DUE BY ORIENTATION DAY

PROOF OF IMMUNITY/ NON-INFECTIOUS BY TITER

Titers MUST include lab work with IgG serum level

1	**MMR – Measles, Mumps, Rubella**
2	**Hepatitis B**
3	**Varicella**
4	**Tuberculosis (annual)**
5	**TDAP – Tetanus, Diphtheria, Pertussis**
6	**Physical Exam (annual)**

Certifications & Vaccine Administration Record (VAR)

VAR *(vaccine name, date of administration, lot #, expiration date, manufacturer, practitioner's signature/stamp)* is required for all boosters and/or vaccinations.

7	**Influenza (seasonal, annual)**
8	**COVID + 1 Booster (or single dose bivalent if received after 4/2023)**
9	**BLS** - American Red Cross [ARC] BLS or American Heart Association [AHA] BLS. **REQUIRED for RN students** ***AHA BLS provided for the PN Program ONLY***
10	**Drug Screen** – urine drug screen must be **OBSERVED**. Or blood (serum) drug screen acceptable
11	**Finger Printing** – May be required depending on clinical rotation. School will notify students at the time.

Refer to the Jersey College website, under Policies, for applications for ADA accommodations, Medical or Religious exemptions.

Submit documentation directly through your portal account in Logiforms (same one as Admissions)

For ANY questions regarding medical documentation – please email medicals@jerseycollege.edu

The medical file must be up-to-date every term – a minimum of 2 (two) weeks prior to the start of the term or the student may be put on an Involuntary Leave of Absence. It is the student's responsibility to know the expiration date(s) of their documents.

The student MUST notify the college immediately if they contract a communicable disease, or have a change in their medical well-being that would negate their previous fit for duty status.

EFFECTIVE 08/2023

JERSEY COLLEGE

Health History and Physical Examination Record For Enrollment in Nursing Program

Patient Data

Last Name	First Name	Middle Name
Date of Birth (MM-DD-YYYY):		Sex:

Vaccine	Titer Test Results		Date of Test [MM/DD/YYYY]	Requirement
Mumps	☐ Positive	☐ Negative		Titers [IgG] less than 5 years old – include lab work If titer [IgG] results are equivocal, low or negative, must receive Booster *include VAR*[1] or Two-dose vaccine *include VAR*[1]. To qualify for booster, must have proof of childhood vaccines or medical record of the disease. *Vaccinations must have been received after your first birthday and must have been received in 1969 or later. Vaccinations must have occurred in the United States.*
Rubella (German Measles)	☐ Positive	☐ Negative		
Rubeola (Measles)	☐ Positive	☐ Negative		
Varicella (Chicken Pox)	☐ Positive	☐ Negative		
Hepatitis B	☐ Positive	☐ Negative		Titers [IgG] less than 5 years old – include lab work or Three-dose vaccine within the past 5 years, *include VAR*[1]. If titer results are non-reactive, must sign waiver
TDAP (Tetanus, Diphtheria, AND Pertussis)	☐ Positive	☐ Negative		Vaccine less than 8 years old, *include VAR*[1] or Titers [IgG] less than 1-year-old – include lab work. Vaccine or titer must include Pertussis
Influenza (flu)	Vaccine for the current influenza season (September 1st – May 31st), *include VAR*[1]			
COVID-19 + Booster	Single-dose (J+J) plus booster, *include VAR*[1] or Two-dose plus booster, *include VAR*[1] or If not vaccinated prior to May 2023, Single-dose of Bivalent booster, *include VAR*[1]			
Drug Test/Screening	Date of Test: _____ **Urine drug screen must be OBSERVED (include results & Drugs custody control page)			
Mycobacterium Tuberculosis	QuantiFERON or TSpot with lab results, less than 1-year-old or 2-Step PPD less than 1-year-old with results (Each Step must be read within 48 – 72 hours; Step 1 & 2 to be completed within 7 – 10 days) or Chest x-ray report less than 5 years old. If lab results or PPD are positive, Chest x-ray report is required. If Chest x-ray report is positive, medical clearance letter required. Complete attached form. *Lab work and 2-Step due annually*.			

Physical Exam Affirmation[2]

Based on review of the patient's medical history, immunization records, and physical examination performed and on file in my office this date _____, it is my impression that the above patient has received the required immunizations and that he/she meets the physical and mental requirements for attendance at the nursing program at Jersey College. I certify that the information herein is complete and accurate to be best of my knowledge. Jersey College complies with the requirements of Section 504 of the Rehabilitation Act and the Americans with Disabilities Act of 1990 and will make reasonable accommodations for a student with a disability that is otherwise qualified. **Requests for accommodation forms may be obtained by contacting the college at the numbers below.**

Name of Examining Practitioner: _____

License No: _____

Address: _____

Signature: _____ Date: _____

Please Stamp with Official Office/Practitioner Seal

1. Vaccine administration record (VAR) is required for all immunizations given (vaccine name, lot #, expiration date, manufacturer, practitioner's signature/stamp)
2. Physical Exam Affirmation (fit for duty) must be less than 6 months old at time of admission; renew and submit annually.

JERSEY COLLEGE

Mycobacterium Tuberculosis Two Step Skin Test

Patient Data

Last Name	First Name	Middle Name

Two Step Skin Test and Results for Mycobacterium Tuberculosis

Test 1	Test 2
Date and Time Test Administered:_____	Date and Time Test Administered:_____
Administrated by:_____	Administrated by:_____
Manufacturer of PPD:_____	Manufacturer of PPD:_____
Expiration Date:_____ Lot #:_____	Expiration Date:_____ Lot #:_____
Date and Time Test Read:_____	Date and Time Test Read:_____
Read by:_____	Read by:_____
Results (in millimeters of induration):_____	Results (in millimeters of induration):_____
Results Attached: ☐	Results Attached: ☐

Record of Tuberculosis Blood Test (aka Interferon Gamma Release Assay "IGRA")

Note: Test Must Be Good for 1 Year

☐ **QuantiFERON®-TB** ☐ **T-SPOT®.TB** **MUST Attach Lab Results**

Date and Time Test Administered:_____

Laboratory:_____

Qualitative result:_____ Nil (IU IFN-g):_____

Mitogen (IU IFN-g):_____ M. TB antigens (IU IFN-g):_____

Record of Treatment Completion

TST: Date:_____ Results (in millimeters of induration):_____

IGRA: Date:_____ Type of test:_____ Result:_____

Chest radiograph: Date:_____ Results:_____ **MUST Attach CXR Report**

Date medication started:_____ Date completed:_____

Medication(s):_____

Name of Examining Practitioner: _____

License No: _____

Address: _____

Signature: _____ Date: _____

Please Stamp with Official Office/Practitioner Seal

JERSEY COLLEGE

Waiver of Immunization Against Hepatitis B

First Name:	
Middle Name:	
Last Name:	
Date of Birth: (MM-DD-YYYY)	

Jersey College has recommended to me the Hepatitis B immunization to protect me from exposure to Hepatitis B during my studies, including in the clinical environment.

I have read the Hepatitis B Frequently Asked Questions located on The Center for Disease Control and Prevention at http://www.cdc.gov/ncidod/diseases/hepatitis/b/faqb.htm, and reviewed the risks associated with the disease, including the effectiveness and availability of any vaccine against Hepatitis B. I understand that Hepatitis B (HBV) is a serious viral infectionof the liver that can lead to chronic liver disease, cirrhosis, liver cancer, liver failure, and even death. The disease is transmitted by blood and or body fluids and many people will have no symptoms when they develop the disease. This disease is completelypreventable. Hepatitis B vaccine is available to all age groups to prevent Hepatitis B viral infection. A series of three (3) doses of vaccine are required for optimal protection.

I choose not to be vaccinated against Hepatitis B. I understand that this may cause me to contract Hepatitis B during my studies. I am fully responsible for this decision, and agree not to hold liable Jersey College, SSS Education, Inc. or any of the college's clinical affiliates should I contract Hepatitis B as a result of my decision to refuse immunization.

Signature _____ Date _____