

IMMUNIZATION AND TESTING

1. Tuberculosis Testing

A TB Skin Test is required **Annually** to participate in health related programs. This consists of a small needle being used to put some testing material, called tuberculin, under the skin. In 2-3 days, you return to the health care worker who will check to see if there is a reaction to the test. Tb tine tests are not acceptable per state regulations. If the student recently received an MMR or varicella vaccine, the tuberculosis test must be postponed until at least four to six weeks after the MMR.

TB Skin Test

Date given: _____

Date read: _____

Result: _____ mm.

Read by: _____

If this test or a previous test is positive: Submit documentation of positive PPD and a negative chest x-ray report from within the past five years. If your previous chest x-ray or positive PPD has been more than a year ago, please complete an Annual Health Evaluation form found at <http://cscce.edu/Students/FormsPDF/health/Annual.pdf>.

2. Hepatitis B Vaccine Series

Provide documentation from your physician, health care provider, or employer.

Date of Hep B#1: _____ Hep B#2: _____ Hep B#3: _____

It is the policy of Columbus State Community College not to discriminate against any individual or groups of individuals in the College's programs or policies. This assurance of non-discrimination includes applicants for academic admission, students, and shall be applied regardless of sex, race, color, religion, national origin, ancestry, age, disability, genetic information (GINA), military status, sexual orientation, and gender identity and expression.

I certify that the health information I have given is accurate and complete. I understand that providing false information on this document is a serious offense which will result in disciplinary action. I understand that if my health, physical condition, or physical abilities change during my enrollment in a health-related program at Columbus State Community College I must report these changes to my program coordinator and to the Health Records Office. I understand that physical exam and tuberculin testing results may be released to clinical sites prior to my clinical/practicum experiences. I understand that conditions which may affect my ability to perform essential functions of the clinical tasks or which may affect my ability to function with safety for myself and/or others might be discussed with my department chair or program coordinator.

Submit completed health record to: Columbus State Community College, Health Records Office, Union Hall Room 132, 550 East Spring Street, Columbus OH 43215; or fax to 614-287-5386, including current name and Cougar ID on all faxed pages. You may also email your Health Record to healthrecords@cscce.edu Emails will only be accepted from your student email account (@student.cscce.edu) QUESTIONS?? Call 614-287-2450

Student Signature

Date

WAIVER FOR HEPATITIS B IMMUNIZATION

NAME: _____

SS#: _____

I understand that due to my educational or occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I also understand or have had explained to me that Hepatitis B is a very serious infection of the liver which can cause me significant illness or death. I understand that if I become infected with Hepatitis B, I can infect others through blood-to-blood contact or through sexual contact. I understand that the Hepatitis B immunization could protect me from the Hepatitis B infection.

Despite knowing this, I request a waiver from the Hepatitis B immunization requirement. In choosing not to receive the Hepatitis B immunization, I understand that I continue to be at risk of acquiring Hepatitis B infection. Should I become infected with Hepatitis B during my studies or employment, I will not hold Columbus State Community College or any of its associates or affiliates liable for any consequences in perpetuity.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

TECHNOLOGY/DEPARTMENT: _____

WITNESS: _____