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1	Student Health Form		
This form must be completed by your health care provider (HCP) no more than twelve (12) months prior to your first clinical assignment. Both you and your HCP must sign and date this form.			
Summary of Major Components	Tuberculosis You must provide proof (<i>i.e.</i> , a copy of the lab results) of an annual TB test. Currently, there are three (3) options available:		
	Skin Test	Bloodwork / Titers	Chest X-Ray
	Two-Step Mantoux	Quantiferon Gold, T-SPOT	
	Must be read 48-72 hours after each injection. Injections must be 7-21 days apart. After the first 2-step test, an annual 1-step is required BEFORE the old test expires.	Only requires 1 trip to the HCP. Results are either negative (no indication of TB infection) or positive (TB infection possible). After the first titer, an annual titer is required BEFORE the old titer expires.	Chest X-rays are indicated if a skin test or blood titer results show a possible TB infection. Chest X-rays expire two (2) years after the read date.
	If test results indicate a possible TB infection, you must complete and return the <i>TB Questionnaire</i>.		
	YOU MUST PROVIDE COPIES OF ALL TB TEST RESULTS WHETHER YOU CHOOSE SKIN TEST, TITER OR CHEST X-RAY.		
	Hepatitis B Typically, most people receive a series of three (3) Hep B vaccinations during childhood. The only way to confirm immunity is through a blood test, or titer.		
	If you opt to have a titer and the results indicate immunity to Hep B, no further action is required on your part.		
	If your titer does not indicate immunity to Hep B, your HCP might recommend 1 – 3 additional Hep B vaccinations and you must complete the <i>Hep B Waiver</i> in order to participate in clinical rotation.	If you have received Hep B vaccinations but opt not to have a titer, you must complete the <i>Hep B Waiver</i> in order to participate in clinical rotation.	
	IF YOU CHOOSE TO HAVE HEP B BLOOD TITERS DRAWN, YOU MUST PROVIDE COPIES OF THOSE LAB RESULTS.		
Immunizations Most people receive a series of two (2) “boosters” to protect them from Measles (<i>Rubeola</i>), Mumps and Rubella (collectively, “MMR”) and two (2) “boosters” to protect them from Chicken Pox (<i>Varicella</i>) during childhood. TDAP (<i>Tetanus, Diphtheria and Pertussis</i>) vaccinations are required every 10 years. Students must provide proof of immunity for these communicable diseases in 1 of 2 ways:			
#1 – Provide the dates that MMR and Varicella boosters were administered.	#2 – Provide titer results confirming immunity.		
YOU MUST PROVIDE COPIES OF ALL BLOOD TITER RESULTS.			

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2	TB Questionnaire You must complete and return this form if your TB test indicates a possible TB infection. If your TB test results are negative (no sign of infection) you may discard this form.	
3	Hep B Waiver You must sign and return this form if you do not have titer results showing immunity to Hep B. If your Hep B titer results are negative (you are immune) you may discard this form.	
4	Health Liability Waiver and Proof of Health Insurance You must sign and return the <i>Health Liability Waiver</i>. You must provide a copy of the front and back of your health insurance card. Your name must be listed on the card as either the policyholder or a covered dependent. <u>If your name is not shown on the card</u> , obtain a list of covered dependents from your insurance carrier and submit that along with the copy of your insurance card.	
5	Latex Allergy Questionnaire Whether or not you are normally exposed to products containing latex, you must complete and return this form.	
6	Influenza Vaccination Record You must submit proof that you have received the seasonal flu vaccination each year, usually after the 1st of September. <u>To decline the vaccination</u> , you must provide a letter from your HCP – on office letterhead and signed by your HCP – stating the medical reasons for declination.	
7	COVID-19 Vaccination Record Federal regulation has removed the mandate for CoVid-19 vaccination(s) for hospital staff. JJC advises all students to continue to provide vaccination documentation unless advised to the contrary.	
CPR CERTIFICATION		BASIC LIFE SUPPORT
JJC and her affiliate clinical sites only accept the curriculum of the American Heart Association Basic Life Support (CPR and AED) Program.		 
https://cpr.heart.org/en/cpr-courses-and-kits/healthcare-professional/basic-life-support-bls-training		
?	If you have any questions, do not hesitate to contact: Linda Saveas, Program Coordinator fsaveas@jjc.edu 815.280.2796 Chris Chierigatti, Secretary cchierig@jjc.edu 815.280.2336 Krystyna Starcevich, Compliance kstarcev@jjc.edu 815.280.6819	

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JOLIET JUNIOR COLLEGE 1901

Nurse Assistant Student Health Form

Please include copies of all lab reports!

PLEASE PRINT LEGIBLY

Your Name: _____

Street Address: _____

City, State, Zip: _____

Telephone: () _____

Student ID #: _____

Date of Birth: _____ Sex: M F

Complete ONE of the following options:

Two-Step Mantoux* Tuberculin Skin Test

#1 Date Given: _____ Date Read: _____ Neg [] Pos []

#2 Date Given: _____ Date Read: _____ Neg [] Pos []

*Mantoux must be read 48 - 72 hours after each injection and injections must be 7 - 21 days apart. After initial two-step test, an annual one-step is required BEFORE the current test expires.

T-SPOT (Complete annually)

Date Given: _____ Neg [] Pos []

Quantiferon Gold (Complete annually)

Date Given: _____ Neg [] Pos []

Current Chest X-Ray: (Expires 2 years from read date)

Indicated when skin test is positive.

Date Read: _____ Neg [] Pos []

*If TB test is positive, complete the TB Questionnaire form.

Hepatitis B Vaccines

Date(s) given: #1: _____ #2: _____ #3: _____

Hepatitis Titer

Date: _____ Results: _____

This vaccine is recommended to protect the student from potential risks. If you do not submit positive ("immune") titer results, you must sign and return the Hepatitis B Declination Waiver (#3).

IMMUNIZATIONS

TDAP Booster Date: _____

Diphtheria/Tetanus/Pertussis (Required every 10 years)

TITER REPORTS

Immunity is required for these communicable diseases:

Table with columns: Disease, Titer Value, Immune? (Y/N). Rows: Measles (Rubeola), Mumps, Rubella.

Or proof of two past MMR vaccinations.

MMR #1

Date Given: _____

MMR #2

Date Given: _____

Varicella (Chicken Pox) _____ [Y] [N]

Or proof of two past Varicella vaccinations.

(2) Varicella Boosters

Date Given: _____ & Date Given: _____

To be completed by Health Care Provider (HCP) no more than 12 months prior to clinical assignment.

Date of Physical Exam: _____

Is this student acceptable for clinical participation without restrictions? [Yes] [No]

If no, please list the restriction(s) and suggested accommodations:

Physician/HCP

Signature

Printed Name: _____

Telephone: _____

Address: _____

City, State, Zip: _____

Date Completed:

I am a student at Joliet Junior College and I authorize J.J.C. to release a copy of this form to clinical sites.

Student Signature



Signature Date

Please include copies of all lab reports!



TB Clearance Questionnaire

To be completed if TB test results are **positive**.

Check the appropriate response below:

Have you been experiencing any of the following:

- Low-grade fever?
- Loss of appetite?
- Increased fatigue?
- Weakness?
- Unexplained weight loss?
- Night sweats?
- Persistent cough?
- Increased phelgm production?
- Chest pain?
- Blood-streaked sputum?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

If you answered "Yes" to any of the questions above or are **newly positive at 5mm**:

- Have you been out of the country within the last year?
- Do you have a medical condition that would affect your immune system?
- Have you been in recent close contact with any person who has active tuberculosis?
- Have you ever had a chest x-ray that was not normal?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

If you answered "Yes" to any of the questions above, please provide details below (i.e., dates, illness(es) treatment(s), etc.).

Student Name PRINTED	Student Signature
Date	



HEPATITIS B WAIVER

(To be signed by student if Hep B titer is negative and does not confirm immunity)

I understand that due to my occupational exposure to bloodborne pathogens or other potentially infectious materials I may be at risk of acquiring the Hepatitis B virus (HBV) infection.

Prior to my assignment in a hospital or other healthcare agency, I have been asked to submit Hepatitis B Surface Antibody (AB) Index blood titer results, at my own expense, to determine my immunity to the Hepatitis B virus and have declined **OR** my blood titer results were non-reactive (not immune).

I understand that this Hep B Waiver must be signed if I have insufficient immunity based on my titer results or if I am in the process of or plan to obtain additional Hepatitis B vaccinations.

I hereby act for myself, my executors, administrators, heirs, next of kin, successors and assigns and waive, release, agree not to sue, and discharge from any and all liability Joliet Junior College, its governing board, employees and agents, successors and assigns for my death, disability, personal injury, illness or action of any kind which may hereafter accrue to me as a result of my exposure to the Hepatitis B virus infection.

STUDENT NAME:

DATE:

STUDENT SIGNATURE:

HEALTH LIABILITY WAIVER

**All students must sign the Health Liability Waiver
and provide proof of health insurance as detailed below.**

I hereby state that I understand that any and all healthcare costs I incur while acting in a nursing student capacity will be my responsibility. Joliet Junior College is NOT responsible for any emergency care, screening, diagnostic, and/or treatment costs that may result from my contact with clients or from any other incident while acting in a student nurse role.

STUDENT NAME:

DATE:

STUDENT SIGNATURE:

PARENT SIGNATURE (if under 18):

Provide a copy of the front and back of your health insurance card.

Your name must be shown on the card as either the policy holder or a covered dependent.

LATEX ALLERGY QUESTIONNAIRE FORM

Check the appropriate response below:

Yes	No
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Do you think you have allergies to natural rubber latex?

<input type="checkbox"/>	<input type="checkbox"/>
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Do you have a food allergy (*i.e.*, hives; facial, lip or tongue swelling) to bananas, kiwi, potatoes, tomatoes, avocado, chestnuts, hazelnuts, grapes, cherries, apple, papaya, carrots or celery?

<input type="checkbox"/>	<input type="checkbox"/>
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Do you wear latex gloves to do your job?

<input type="checkbox"/>	<input type="checkbox"/>
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When you, or the people with you wear latex gloves, do you notice any itchy, red eyes, sneezing, runny or stuffy nose, itching inside the mouth, shortness of breath, wheezing, chest tightness or difficulty breathing?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Have you had any itching, swelling, or other symptoms, or unexplained allergic reactions after **dental** or **medical procedures**?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Have you ever reacted to latex products (*i.e.*, gloves, balloons, condoms, ace wrap, urinary catheters, or diaphragms)?

<input type="checkbox"/>	<input type="checkbox"/>
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Do rubber bands, rubber handles, or elastic bands on clothing cause any discomfort?

<input type="checkbox"/>	<input type="checkbox"/>
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Student Name PRINTED

Student Signature

Date

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INFLUENZA VACCINE FORM

Students must submit proof of the influenza vaccine by November 1st.

To ensure that you receive the most current strain,
the vaccine must be administered after September 1st.

Signature / Stamp of Healthcare Provider	Date	Lot Number

Student's Name PRINTED	
Student's Signature	Date

If you received the vaccine at a pharmacy (*i.e.*, Walgreen's, CVS, etc.) or another provider, please attach a copy of the receipt (below) that includes your name, the date the injection was administered, and the vaccine lot number.

Attach receipt in this area.

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JOLIET JUNIOR COLLEGE
DEPARTMENT of NURSING
1215 Houbolt Road, Joliet, IL 60431 |
815.280.2435
www.jjc.edu

COVID VACCINATION FORM

#1	<input type="checkbox"/>	Johnson & Johnson	Date	Lot Number
	<input type="checkbox"/>	Moderna		
	<input type="checkbox"/>	Pfizer		

#2	<input type="checkbox"/>	Moderna	Date	Lot Number
	<input type="checkbox"/>	Pfizer		

Booster Information

#1	<input type="checkbox"/>	Johnson & Johnson	Date	Lot Number
	<input type="checkbox"/>	Moderna		
	<input type="checkbox"/>	Pfizer		

#2	<input type="checkbox"/>	Johnson & Johnson	Date	Lot Number
	<input type="checkbox"/>	Moderna		
	<input type="checkbox"/>	Pfizer		

Student's Name PRINTED

Student's Signature

Date



Please attach a copy of your CDC Vaccination Card (below) that includes your name, the date the injection(s) were administered, and the vaccine lot number(s).

Attach a copy of your CDC vaccination card in this area.