I give consent for PPSC NUA Program to share the results of the immunizations and physical questionnaire with clinical agencies as requested _____ _____
(Student Signature) (Date)

PIKES PEAK STATE COLLEGE

Pikes Peak State College NUA Program Health and Immunization Record

Name_____
Last First Middle

Date of Birth ☐☐☐ Age____ PPCC S Number _____ Last 4 of Social Security Number _____
Mo Day YR

Part A: Parts A & B TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. Enter all information in English.

I. REQUIRED FOR ALL STUDENTS.

Tetanus, Diphtheria & Pertussis (Tdap)-booster must be within the last ten years… ☐☐ Mo Yr

MMR (Measles, Mumps, Rubella)
Two doses required, at least one month apart……..Dose #1 ☐☐ Mo Yr Dose#2 ☐☐ Mo Yr

OR ALL 3 OF THE FOLLOWING CRITERIA ARE MET:

MEASLES (RUBEOLA)
Has report of positive immune **titer**. Specify date: ☐☐ Mo Yr Or **two doses** of individual rubeola vaccine
Dose #1 ☐☐ Mo Yr Dose #2 ☐☐ Mo Yr

RUBELLA (GERMAN MEASLES)
Has report of positive immune **titer**. Specify date: ☐☐ Mo Yr Or **two doses** of individual rubella vaccine
Dose #1 ☐☐ Mo Yr Dose #2 ☐☐ Mo Yr

MUMPS
Has report of positive immune **titer**. Specify date: ☐☐ Mo Yr Or **two doses** of individual mumps vaccine
Dose #1 ☐☐ Mo Yr Dose #2 ☐☐ Mo Yr

HEPATITIS B:
Has report of positive immune **titer**. Specify date: ☐☐ Mo Yr Or **three doses** of individual hepatitis vaccine
Dose #1 ☐☐ Mo Yr Dose #2 ☐☐ Mo Yr Dose #3 ☐☐ Mo Yr

VARICELLA (chicken pox): Two doses one month apart recommended for adults with no history of disease:
Has report of positive immune **titer**. Specify date: ☐☐ Mo Yr
(*History of disease cannot be accepted*)
or Dose #1 ☐☐ Mo Yr Dose #2 ☐☐ Mo Yr

I attest that I have examined the individual named above and to the best of my knowledge he/she is in good physical health and capable of performing the minimum technical standards outlined in the NUA course handbook.

Health Care Provider with Title: _____ _____ _____
(Print name) (Signature) (Date)
Address and Phone number required_____

PART B: Tuberculosis Screening and Influenza Vaccine

Name: _____ Date of Birth _____S#: _____

Continue on to Part B for Tuberculosis Screening and Influenza Vaccine (Required for all students)

1. Does the student have signs or symptoms of active TB disease? ☐ YES ☐ NO

If NO, proceed to 2.

If YES, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

PLEASE USE THE SPACE BELOW TO DOCUMENT TUBERCULIN SKIN TESTING AND/OR CHEST RADIOGRAPHY (Based on assessment criteria outlined above)

2.

A. Tuberculin Skin Test/PPD

Date given: ☐☐☐ (Mo Day Yr) Date read: ☐☐☐ (Mo Day Yr) Results: _____MM (Record actual MM of indurations, transverse diameter; if no in duration, write "0")

Interpretation (based on MM of induration's as well as risk factors)

☐ Positive ☐ Negative

B. Chest X-Ray (required if tuberculin skin test is positive or if PPD has not been placed but patient is at risk of disease; must have been performed. Result: ☐ Normal ☐ Abnormal Date of chest x-ray: _____

INH Initiated ☐ Date_____X_____months

C. Quantiferon: Date of Test:_____ ☐ Positive (≥ 0.35 IU/mL) ☐ Negative

History of positive PPD and/or negative Quantiferon results requires annual TB screening with a Healthcare Provider:

1. Have you been having a bad cough that last longer than 2 weeks? ☐ YES ☐ NO
2. Have you been having pain in the chest? ☐ YES ☐ NO
3. Have you been coughing up blood or sputum (phlegm from deep inside the lungs)? ☐ YES ☐ NO
4. Have you experienced weakness or fatigue? ☐ YES ☐ NO
5. Have you experienced chills, fevers, or sweating at night? ☐ YES ☐ NO
6. Have you experienced weight loss or a loss of appetite? ☐ YES ☐ NO

INFLUENZA:

Date of last dose: ____/____/_____
M D YYYY

HEALTH CARE PROVIDER: (signature required as validation of correct information for immunizations and TB assessment)

Name and Title:_____**Address:**_____

Signature:_____**Phone:**_____**Date:**_____