HEALTH PROFESSIONS HEALTH REQUIREMENTS

Nursing Checklist

- ★ **Important:** HEALTH PROFESSIONS (HLTP) health requirements differ from the college health requirements. HLTP students must submit this completed Physical Form.
- ★ **When: HLTP students must have uploaded a completed checklist and all required documents to the vaccine portal at www.mvcccompliance.com . The due date for submission is no later than August 1ST.**
- ★
- ★ **Where to submit: www.mvcccompliance.com .**
- ★ ***Important note**: Students without completed health documents are **not** allowed to attend clinical and will be placed on clinical probation which may lead to dismissal from the program.*

Students: Please take this HLTP Health Physical Form to your Health Care Provider and CHECK to assure your submission is complete as partial submissions will not be accepted.

☐ **Physical obtained yearly the student is attending courses.**	All Physical documentation is due August 1, prior to the start of student's Nursing course. A complete physical is required **every year.**
☐ **Documentation of Tuberculin Test (also referred to as Mantoux or PPD)**	This test is required 3 months prior to a clinical placement. Results must be documented by a Healthcare provider and/or include a copy of the report.
☐ **Full sequence (2 doses) verified for: Rubella, Rubeola, Mumps & Varicella** **OR submit a copy of the titers with Lab reports** ☐ ***1) Rubella titer* Lab results must be positive*** ☐ ***2)Rubeola titer* Lab results must be positive*** ☐ ***3) Mumps titer * Lab results must be positive*** ☐ ***4) Varicella titer * Lab results must be positive***	***What if my lab results are equivocal or negative?*** *If results are **negative** booster shots are required and follow up titers must be scheduled with your healthcare provider. **Students submit positive titers one time only**
☐ **Healthcare provider documentation on the form of Tetanus toxoid**	Immunization within 10 years.
☐ **Students should expect to submit proof of flu vaccine when it becomes available each year or sign a waiver.**	Flu immunization may be required pending clinical site requirements determined each fall. Waiver is found on page 3.
☐ **Documentation on the form of Hepatitis B immunization sequence**	Recommended. Students can receive one of the following: Hep B 3 shot series, 2 shot Heplisav series, Hep B surface antibody titer (Anti-HBs or HBsAb), or students may opt to sign the waiver on page 2.
☐ **Documentation on the form of Meningitis immunization**	Recommended. Students may opt to sign the waiver on page 2.
☐ **Student must provide a COPY of an American Heart Association CPR BLS for the Healthcare Provider**	It must be an **American Heart Association** Healthcare Provider CPR certification. This course is valid for 2 years and cannot expire before all your core courses are complete.

For more information on the above immunizations please visit http://www.immunize.org/vis/

Health Profession (HLTP) Student Physical Health Form

- ***Studen Name:*** _____
- ***Required: Tuberculin Test*** *(Mantoux/PPD) required*

  Admin Date____/____/____ Reading Date____/____/____ Result_____**(Must be repeated yearly)**

  If test is positive: Date of CXR____/____/____Result _____

- ***Required: MMR Sequence*** Dose #1____/____/____ Dose #2____/____/____

  Or Titers*:*

*** *Students must submit a copy of the lab report*. Titer results are required to be positive. Please note that if titer results are negative or equivocal, appropriate booster shots must be administered and a follow up titer appointment scheduled**

1) *Rubella Results _____ Date of booster shot: ____/____/____
2) *Rubeola Results _____ Date of booster shot: ____/____/____
3) *Mumps Results _____ Date of booster shot: ____/____/____

- ***Required: Varicella Sequence*** Dose #1____/____/____ Dose #2____/____/____

  Or Titer* Date____/____/____ Result _____

- ***Required: Tetanus toxoid* within 10 years** Date____/____/____
- ***Required: Covid-19 vaccine (either 2 dose vaccine or single dose)***
  Type: Pfizer Moderna Johnson/Johnson

  Dose #1 ___/___/___ Dose #2 ____/____/____ Booster ____/____/____

- ***Recommended: Hepatitis B sequence*, student waiver listed below.**
- Requirement: 3 doses of HepB vaccine, 2 doses of HepSlav vaccine, positive Hepatitis surface antigen antibody titer (Anti-HBs or HBsAb), or sign the waiver.

  Shots Dose #1____/____/____ Dose #2____/____/____ Dose #3____/____/____

  Or Titer* Date____/____/____ Result _____

Waiver: I have read, or have had it explained to me, the information regarding Hepatitis B disease.
I understand the risks of not receiving the vaccine. I have decided that I will not obtain testing and/or immunization.

X_____ **X**_____
Student's signature Age Parent/guardian signature (under 18 years old)

- **MENINGITIS RESPONSE**
  Check one box: I have (for students under the age of 18: My child has):
  - ☐ had a meningococcal immunization within the past 5 years. The vaccine record is attached.
  - ☐ I plan to obtain immunization against meningococcal disease within 30 days from my private health care provider or other public or private health care provider.
  - ☐ I have either read, received, or acknowledge the website link below containing the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child, if under 18) will NOT obtain immunization against the meningococcal disease at this time.
    http://www.mvcc.edu/health-center/meningitis

X_____ **X**_____
Student's signature Age Date Parent/guardian signature (under 18 years old)

- **Recommended:** ***Current fall Influenza Vaccine or waiver below.*** Date___/_____/_____
    - I have been advised that I should receive the influenza vaccine to protect myself and the patients I serve. I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a healthcare provider. I am aware of the following facts:
        - Influenza is a serious respiratory disease that kills thousands in the United States each year.
        - Influenza vaccination is recommended for me and all other healthcare personnel to protect this facility's patients from influenza, its complications, and death.
        - If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
        - If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
        - I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't, my immunity declines over time. This is why vaccination against influenza is recommended each year.
        - I understand that I cannot get influenza from the influenza vaccine.
        - The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in this healthcare facility, coworkers, my family and my community.
        - I understand that I may be denied placement at certain clinical sites due to refusing a flu shot.
        - *Because I have refused vaccination against influenza, I will be required to wear surgical or procedure masks in areas where patients or residents may be present during the influenza season.*

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

MVCC Nursing Program Essential Functions

The essential skills and relevant activities are listed for your review so that potential students and healthcare providers can decide whether or not they may be able to complete the requirements for the radiology program. MVCC complies with the Americans with Disabilities Act of 1990. The college will endeavor to make reasonable accommodations for an applicant with a disability, who is otherwise qualified. Applicants who are unsure if they can meet these essential skills or know they will need help in meeting them should contact the College's Disability Services Office (315) 792-5644 to discuss accommodations and/or auxiliary aids.

A student in the associate degree radiology program must have the abilities and skills necessary for use of the nursing process. The following is a representative list of the essential skills, with or without accommodation, expected of students enrolled in the Nursing program.

1. Demonstrate the ability to perform essential functions for a maximum of a 10 hour shift.
2. Demonstrate the ability to protect a client when the client is standing and ambulating on all surfaces with or without the use of assistive devices, including canes, crutches and walkers.
3. Demonstrate the ability to safely move a client over 100 pounds from one surface to another using the appropriate level of help.
4. Demonstrate safe body mechanics in the process of all client treatments, including lifting and carrying small equipment (under 50 pounds) and moving large equipment (over 50 pounds).
5. Demonstrate the ability to manipulate dials on equipment.
6. Demonstrate the ability to coordinate simultaneous motions.
7. Demonstrate the ability to perform occasional overhead extension.

8. Demonstrate the ability to hear blood pressure, heart and lungs sounds with or without corrective devices.
9. Demonstrate the ability to palpate soft tissue including pulse, muscle and bones.
10. Demonstrate the ability to perform nursing interventions such as sterile procedures, dressing changes following infection control procedures.
11. Demonstrate the ability to administer medications (IM, Subcutaneous, IV, suppositories etc. (including dosage calculations) when necessary.
12. Display adaptability to change,
13. Establish effective relationships with others.
14. Communicate effectively, safely and efficiently in English (both written and spoken) by:
    a. Explaining procedures
    b. Receiving information from others
    c. Receiving information from written documents
    d. Exhibiting appropriate interpersonal skill (refer to ANA Code of Ethics for Nurses)
    e. Analyzing and documenting assessment findings and interventions.
15. Distinguish color changes.
16. Detect an unsafe environment and carry out appropriate emergency procedures including:
    a. Detecting subtle environment changes and odors including, but not limited to, the smell of burning electrical equipment, smoke, and spills.
    b. Detect high and low frequency sounds, including but not limited to, alarms, bells, and emergency signals.

If there are any reasons why you may not be able to perform these functions with or without reasonable accommodations, you must notify the Program Coordinator, Clinical Coordinator, or Clinical Instructor immediately.

This student has had a complete physical, can complete the Essential Functions, and is in satisfactory physical condition to care for infant, child, and adult patients in an actual hospital/clinical setting.

Health Care Provider Signature:_____ Date:____/____/____

Health Care Provider Name and Title (Print): _____

Address_____ Phone (_____)_____

CPR CERTIFICATION FORM

☐ Print e-card from https://ecards.heart.org/student/myecards

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MVCC offers a CPR BLS for Healthcare Professionals
Certification from the American Heart Association
Please visit https://www.mvcc.edu/CCED or call (315) 792-5300 for more information.

Student must obtain American Heart Association BLS course and keep valid throughout the clinical experience. Any lapse in CPR course will result in student being removed from clinical and possibly dismissed from the course. BLS card must be uploaded to www.mvcccompliance.com .

STUDENT EMERGENCY CONTACT FORM

Name _____

M# _____ Date of Birth _____

Personal Contact Info:

Home Address _____

City, State, ZIP _____

Home Telephone # _____ Cell # _____

Emergency Contact Info:

(1) Name_____ Relationship_____

Address _____

City, State, ZIP _____

Home Telephone # _____ Cell # _____

Work Telephone # _____ Employer_____

(2) Name_____ Relationship_____

Address _____

City, State, ZIP _____

Home Telephone # _____ Cell # _____

Work Telephone # _____ Employer_____

Medical Contact Info:

Doctor Name._____ Phone # _____

Dentist Name_____ Phone # _____

○ I have voluntarily provided the above contact information and authorize MVCC and its representatives to contact any of the above on my behalf in the event of an emergency.

○ I choose not to furnish any emergency contact information to MVCC at this time.

Student Signature_____ Date_____