UPPER CAPE COD REGIONAL TECHNICAL SCHOOL
PRACTICAL NURSING PROGRAM

HEALTH CLEARANCE

Name of PN Student: _____ Date of Birth: _____

ALL HEALTH DOCUMENTS ARE RETAINED IN A LOCKED FILE CABINET INSIDE A LOCKED CLOSET.

*For the protection of students, patients, faculty, and other personnel, individuals accepted to the Practical Nursing (PN) Program must provide **documented proof of compliance with the immunization requirements** (see reveres side).*

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

This is to verify that _____, was examined by me on _____.

Summary of findings:

☐ Well student; no conditions identified that would limit the ability to participate in the PN program and safely perform nursing activities.

☐ Conditions have been identified that would limit the ability participate in the PN program and perform nursing activities. The identified condition(s) does not pose a risk to safe nursing practice. *Please identify condition, limitations, rationale for, and duration of the specific limitations.*

By signing below, I find her/him be free of any health impairment which is of potential risk to students, patients, faculty, and other personnel and which might interfere with the safe performance of her/his nursing student responsibilities, with or without reasonable accommodation. Habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances that may alter the individual's behavior has been considered in this evaluation.

Signature* of Examining Healthcare Provider: _____

(*Stamp in NOT acceptable in place of signature) Date: _____

Stamp, copy of letterhead, or business card may be used for the following required information:

Print or type name

Office or Agency

Address

Telephone number

STUDENT: Please retain a copy of this document for your records.

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IMMUNIZATION REQUIREMENTS

In accordance with the regulatory requirements of the Massachusetts Board of Registration in Nursing, the candidate for admission (*the applicant*) must provide satisfactory evidence of compliance with the immunization requirements specified by the Massachusetts Department of Public Health (ref: 244 CMR 6.04(3)(a)1). These requirements are available at: https://www.mass.gov/files/documents/2018/07/02/guidelines-adult.pdf .

Certain clinical agencies have immunization requirements that exceed those of the MA Department of Public Health and as a result the Program cannot make any exceptions. Failure to provide all required documentation may exclude the PN student from clinical practice and participation in the Program.

- **Hepatitis B, Measles, Mumps, Rubella, and Varicella [Required for admission]**
  A lab report (on lab letterhead and obtained from the lab performing the test, NOT documentation from a medical record) that documents that the student has sufficient antibody protection against Hepatitis B, measles, mumps, rubella, and varicella. Dates of immunizations, without these titers, will not be accepted.

- **Tdap/TD [Required for admission]**
  Documentation of ADULT pertussis-containing vaccine within 10 years of time of application to the Program. If the 10 year duration of the vaccine will lapse at any time during Program enrollment, the applicant is required to receive the immunization prior to admission to the program.

- **Tuberculosis Screening [Required to attend clinical]**
  A tuberculosis test is required within 3 months of the start of clinical, [Day option: after July 1st ; Evening option: after November 1st]. In accordance with the policy of the MA DPH Tuberculosis Program, a history of BCG immunization does not exempt the student from TB screening requirement. A negative chest X-Ray and clinical evaluation is required for those with a history of positive PPD.

- **Influenza Vaccination [Required to attend clinical]**
  Mandatory influenza vaccination is required by all clinical facilities. The flu vaccine is due annually on or before October 15th.

Acceptance to the Program is contingent upon submission of complete and verifiable documentation demonstrating compliance with the immunization requirements.

Applicant's acknowledgement of UCT PN Program Health and Immunization Requirements

I have read and fully understand he mandatory Program requirements outlined above. I understand the failure to meet these requirements exclude me from consideration for admission to the Program.

Applicant Signature: _____ Date: _____

Printed Name: _____

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