DMACC
DES MOINES AREA COMMUNITY COLLEGE

HEALTH AND PUBLIC SERVICES DEPARTMENT
STUDENT HEALTH AND IMMUNIZATION RECORD

Program in which you are enrolling: _____ Campus: _____

All students enrolling in the health and early childhood programs must complete Part I of this form before consulting with a health care provider (MD/DO, PA, NP) to verify dates of immunizations and treatment of current or chronic conditions. With the exception of immunization information or in the case of medical emergencies, no information will be released to anyone other than the Health and Public Service Department without consent of the student.

Program continuation requires each student to perform every essential function of the student role. If the student, with reasonable accommodation, is unable to perform any essential function in a safe and successful manner, they will be required to withdraw from the program.

PART I: **BACKGROUND INFORMATION** **To be completed by student.** ***(Please Print)***

A. **PERSONAL DATA** Gender: ☐ Male ☐ Female DMACC ID Number: 900

Last Name	First Name	Middle Initial	Date of Birth

Home Address (Number and Street)	City	State	Zip Code

Telephone: Home	Work	Health Insurance Company	Policy Number
		( )	( )

In Case of Emergency, Notify: Name	Relationship	Home Phone	Work Phone

B. **PERSONAL HEALTH HISTORY**

DATE OF MOST RECENT DENTAL EXAM _____
month year

ALLERGIES: If none, write below None Known

Medication Allergies: _____

Other Types (Environmental, food,): _____

I have the following "Med-alert" condition: _____ *(If none write NA)*

OTHER COMMENTS:

Student Signature _____ Date _____

Rev. 2-23

• **Part II Medical History & Part III Immunizations** **TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER**

PART II: **MEDICAL HISTORY** **Student Name** _____

1. **Physical/mental conditions which have required treatment within the last 6 months or are chronic in nature:**

_____

_____

_____

_____

2. **Medications taken currently or routinely:**

_____

_____

_____

_____

3. **Conditions which restrict activity and/or require special adaptation(s):**

_____

_____

_____

4. Other:

_____

_____

_____

5. **Core Performance Standards**:

Please refer to the attached **Iowa Core Performance Standards for Health Career Programs** and indicate if the above named individual may have difficulty meeting any of the eleven standards outlined.

At this time this individual is capable of meeting the performance standards:

____ Agree

____ Disagree. The following limitations are present_____

____ Additional evaluation suggested _____

6. **Date of Physical Exam:** _____

(within one year of program entry) mm/dd/yr

_____ _____

Date **Signature of Health Care Provider (MD, DO, ARNP, PA)**

IOWA CORE PERFORMANCE STANDARDS

Iowa Community colleges have developed the following Core Performance Standards for all applicants to Health Care Career Programs. These standards are based upon required abilities that are compatible with effective performance in health care careers. Applicants unable to meet the Core Performance Standards are responsible for discussing the possibility of reasonable accommodations with the designated institutional office. Before final admission into a health career program, applicants are responsible for providing medical and other documentation related to any disability and the appropriate accommodations needed to meet the Core Performance Standards. These materials must be submitted in accordance with the institution's ADA Policy.

CAPABILITY	STANDARD	SOME EXAMPLES OF NECESSARY ACTIVITIES (NOT ALL INCLUSIVE)
Cognitive-Perception	The ability to gather and interpret data and events, to think clearly and rationally, and to respond appropriately	• Identify changes in patient/client health status • Handle multiple priorities in stressful situations
Critical Thinking	Utilize critical thinking to analyze the problem and devise effective plans to address the problem.	• Identify cause-effect relationships in clinical situations • Develop plans of care as required
Interpersonal	Have interpersonal and collaborative abilities to interact appropriately with members of the healthcare team as well as individuals, families and groups. Demonstrate the ability to avoid barriers to positive interaction in relation to cultural and/or diversity differences.	• Establish rapport with patients/clients and members of the healthcare team • Demonstrate a high level of patience and respect • Respond to a variety of behaviors (anger, fear, hostility) in a calm manner • Nonjudgmental behavior
Communication	Utilize communication strategies in English to communicate health information accurately and with legal and regulatory guidelines, upholding the strictest standards of confidentiality.	• Read, understand, write and speak English competently • Communicate thoughts, ideas and action plans with clarity, using written, verbal and/or visual methods • Explain treatment procedures • Initiate health teaching • Document patient/client responses • Validate responses/messages with others
Technology Literacy	Demonstrate the ability to perform a variety of technological skills that are essential for providing safe patient care.	• Retrieve and document patient information using a variety of methods • Employ communication technologies to coordinate confidential patient care
Mobility	Ambulatory capability to sufficiently maintain a center of gravity when met with an opposing force as in lifting,	• The ability to propel wheelchairs, stretchers, etc. alone or with assistance as available
Motor Skills	Gross and fine motor abilities to provide safe and effective care and documentation	• Position patients/clients • Reach, manipulate, and operate equipment, instruments and supplies • Electronic documentation/ keyboarding • Lift, carry, push and pull • Perform CPR
Hearing	Auditory ability to monitor and assess, or document health needs	• Hears monitor alarms, emergency signals, ausculatory sounds, cries for help
Visual	Visual ability sufficient for observations and assessment necessary in patient/client care, accurate color discrimination	• Observes patient/client responses • Discriminates color changes • Accurately reads measurement on patient client related equipment
Tactile	Tactile ability sufficient for physical assessment, inclusive of size, shape, temperature and texture	• Performs palpation • Performs functions of physical examination and/or those related to therapeutic intervention
Activity Tolerance	The ability to tolerate lengthy periods of physical activity	• Move quickly and/or continuously • Tolerate long periods of standing and/or sitting as required
Environmental	Ability to tolerate environmental stressors	• Adapt to rotating shifts • Work with chemicals and detergents • Tolerate exposure to fumes and odors • Work in areas that are close and crowded • Work in areas of potential physical violence • Work with patients with communicable diseases or conditions

Part III

Name_____ DMACC ID _____ Birthdate: _____

Required Test and/or Immunizations

Form to be completed/signed/dated by licensed health care provider (MD, DO, ARNP, PA). Take immunization records & documentation of disease with you to your appointment. If immunization records are not available, the HCP will determine what vaccinations tests or titers are indicated. **Documentation of items below is required by clinical agencies DMACC contracts with for clinical experience.**

Note: Each must be uploaded by immunization type in View Point

Adult Diphtheria/Tetanus/Pertussis All healthcare personnel (HCP) who have not or are unsure if they have previously received a dose of **Tdap** should receive a one-time dose of Tdap as soon as feasible, without regard to the interval since the previous dose of Td. Then, they should receive Td boosters every 10 years thereafter. HCP Vaccination Recommendations Centers for Disease Control and Prevention, March 2011.	**Date of Tdap** mm/dd/yy Once in a lifetime booster required for Pertussis protection

Varicella (Chicken Pox) Evidence of Immunity includes any one of the following: • Positive titer • Two doses of vaccine • Documentation by HCP of chickenpox or herpes zoster. **Verbal history is not acceptable**	**Must attach copy of Lab results**		Vaccination #1 Date mm/dd/yy	Vaccination #2 Date mm/dd/yy	Documentation of HCP diagnosed Varicella or herpes zoster (Shingles)
	Titer Date mm/dd/yy	Titer Results			
		Must attach copy of Lab results			**Must attach a separate document signed by health care provider who diagnosed disease. Include mm/dd/yy of diagnosis.**

		First dose must be documented prior to submission of this health record and written verification of additional doses submitted as received.		
Hepatitis B **Evidence of immunity is mandatory for all* Health students and includes either** • **Completion of series, OR** • **Positive Titer of HBsAb** *Aging Services Management -Exempt	**Titer HBsAb:** Results/Date **Must attach copy of Lab results**	**Date Dose #1** Required prior to submitting this record	**Date Dose #2 (1-2 months)** mm/dd/yy	**Date Dose #3 (4-6 months)** mm/dd/yy
	Must attach A copy of Lab results			

Date of birth:

MMR All students (regardless of age) must have documentation of either 2 MMR vaccinations **OR** Documentation of sufficient titers for Rubeola, Mumps and Rubella. Those who have an "indeterminate" or "equivocal" level of immunity upon testing should be considered non-immune. **Lab results of titers must be attached to this form.**	**Titers**	**Titer date** mm/dd/yy	Titer results **Must attach copy of Lab results**	If born 1957 or later, 2 doses of live measles and mumps vaccines given on or after the first birthday, separated by 28 days or more.	
				Date MMR #1 mm/dd/yy	**Date MMR #2** mm/dd/yy
	Rubeola IgG		**Must attach copy of Lab results**		
	Mumps IgG		**Must attach copy of Lab results**		
	Rubella		**Must attach copy of Lab results**		

I certify this student has received the immunizations as indicated above or has laboratory evidence of immunity which is attached to this form.

_____ _____ **Date:** _____

Print Name of Health Care Provider **Signature of Health Care Provider (MD, DO, ARNP, PA)**

_____ (_____)_____

Address of Health Care Provider **City** **State** **Zip** **Phone**