HORRY GEORGETOWN TECHNICAL COLLEGE

Health Tracker Clinical Requirements

for

Dental Hygiene

Expanded Duty Dental Assisting

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☐	3.	**Initial Tuberculin Skin Test** 2 Step PPD **OR** QFT Gold Blood Assay 2 Step PPD (4 visits) Step 1 Administered ☐ Step 1 Read Result ☐- ☐+ Step 2 Administered ☐ Step 2 Read Result ☐- ☐+ **OR** QFT Gold Blood Assay Lab Results ☐- ☐+	Initial Step 1 Read: Step 2 Read: QFT Date:		NA
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		IF MMR Titers show NON-IMMUNITY Combination Vaccine x 2 Required (can be given 28 days apart) MMR #1 Date: *Prior MMR vaccination can be used as MMR #1; booster for #2 required MMR #2 Date:	If MMR titers are positive, you may skip		
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		IF Varicella Titer show NON-IMMUNITY Vaccine x 2 Required (can be given 28 days apart) VAR #1 Date: *Prior VAR vaccination can be used as VAR #1; booster for #2 required VAR #2 Date:	If VAR titer is positive, you may skip		
☐	9.	**Certificate of Liability - Insurance (remit the certificate)** Policy Coverage: Up to $1,000,000 each claim professional liability coverage Up to $3,000,000 aggregate professional liability coverage	1 Year		

IMPORTANT NOTES

- Any item that will expire mid semester must be completed before the semester begins. Example, your CPR Certificate expires in March or your QFT expires in April, you must renew these requirements before classes start in January.

- **CPR Certification** – there are many different types of CPR Certification. **BLS (Basic Life Support) for HealthCare Providers through AHA or ARC ONLY is the certification that is required.**

- One year from the date of your physical, a **physical waiver** may be submitted annually ONLY if there has been no change in your health status.

- **2 Step PPD or QFT Gold Blood Assay**
  - A 2 Step PPD is two (2) Tuberculin skin tests. You will visit the physicians/clinics office four (4) times. You have step one administered and then read 48-72 hours later. Seven (7) days later after step one is read, you then have step two administered. Step two is then read 48-72 hours later. There is a max timeframe of 21 days (3 weeks) between Step 1 and Step 2.
  - You may have a QFT Gold Blood Assay in lieu of the traditional skin tests (2 Step PPD). This is a blood draw to test for tuberculosis.
  - After the initial 2 Step PPD or QFT, you will be required to receive a 1 step PPD or QFT Gold Blood Assay yearly. Do not let time lapse or you will need to complete the 2 Step PPD again. Example: If your 2 Step PPD was completed May 1, your annual 1 Step PPD MUST be completed no later than May 1 the following year.
- **If your PPD/QFT is positive**, you must have a chest x-ray immediately following the result. A chest x-ray is then required every 2 years.
- **If your PPD/QFT is positive**, a PPD symptom assessment form must be completed yearly.

- **Hepatitis B** - There are 3 options to choose from:
  - Receive the 3-dose series. You receive the 2nd dose 1 month after the 1st. The 3rd dose is received 5 months after the 2nd. Please check the first box of the Hep B Waiver (page 16), sign, date and upload along with dose # 1 and/or dose #2. *If you received 3 doses in the past, we will accept those as your 3 doses (childhood immunizations).
  - You may have a Hep B Surface Antibody titer to check your immunity. If negative/non-reactive (non-immune), you will need to sign the waiver or begin the 3 series dose. You may use 2 Hep B vaccines from a prior record (childhood, military, etc.) and then just receive a booster to count as the 3rd dose.
  - You may opt out. Please see the Hepatitis Declination Waiver on page 16. Check the second box, sign & date.

- **MMR and Varicella titers are required**. DO NOT go for vaccinations until you have your titers completed. **LAB RESULTS WITH YOUR SCORE AND REFERENCE RANGES ARE REQUIRED FOR MMR AND VARICELLA.** If the titers are positive (immune), you are complete. Simply upload a copy of the positive titer lab results. If negative (non-immune) for the Mumps, Measles or Varicella, 2 boosters/vaccinations are required. Only 1 booster is needed for Rubella. For the 2 boosters, a prior vaccination (childhood, military, etc.) can count as the 1st dose and you will only need to receive the one booster/vaccination. You will need to remit a copy of your immunization record.

- **Liability insurance** – We need the Certificate of Liability, not a copy of the application or proof of payment. If you change programs, your specialty must be changed on your policy. Example, if you are a Phlebotomy student in the spring and then go into the Radiology program for summer, the specialty on your policy must be changed from Phlebotomist to Radiology Technologist.

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

CPR: BASIC LIFE SUPPORT FOR HEALTHCARE PROVIDERS FORM

CPR REQUIREMENT:

- **Basic Life Support Certification for the Healthcare Provider by American Heart Association (AHA) or American Red Cross (ARC) only**
- Must renew CPR certification every 2 years

BLS CPR Completion Date:	**Certifying Agency:**	**Instructor's Initials**	**Expiration Date:**
	☐ AHA ☐ ARC		

Certification:

Signature below indicates verification of above initials in student completion of stated CPR requirement

_____

Printed Name Signature Title (RN, NP, MD)

CPR Instructor Affiliation _____

NOTE: Take this form with you to your CPR class for your instructor to complete. This form serves as temporary documentation for CPR. If it has been more than 30 days, the student is responsible for following up with their BLS Instructor regarding the BLS Card.

Some area CPR/BLS Vendors – Others are also available

Prices and Information Subject to Change

Class Must Be:
BLS (Basic Life Support) Certification for Healthcare Provide from the American Heart Association or the American Red Cross ONLY

Horry-Georgetown Technical College – Workforce Development – Courtney Sterbenz, Program Manager Cost: $105.00 (Materials Included) 950 Crabtree Lane, Building 600, Rm 631 Myrtle Beach, SC 29577 | courtney.sterbenz@hgtc.edu 843-477-2020 OR 843-477-2079 Dates of CPR classes can be found at www.hgtc.edu/jobtraining under Allied Health.	**Horry County Fire & Rescue** 2560 Main St Suite 1 Conway, SC 29526 | 843-915-5190 Melissa Rabonbrownm@horrycountysc.gov Cost: Online Portion - $32.50 - **www.onlineaha.org (Heart Code** BLS) In Person Skills - $15 www.horrycountyfirerescue.com/training
Bless Your Heart – CPR ~ Holly Wittschen Cost: $45.00 (Materials Included) Myrtle Beach / Carolina Forest Area 843-457-3305 holly.wittschen@yahoo.com	**Andy Brown** Cost: $65 Myrtle Beach Area 843-957-0124 ambrownl2345@gmail.com
Midway Fire Department Battalion 82 Training Solutions, LLC Pawleys Island / Litchfield Area 843-545-3627 OR 843-267-2300 cgilmore@gtcounty.org OR mfdbc82@gmail.com http://www.midwayfirerescue.org	**Lovely Day Home Care** Cost: $65 225 Lincolnshire Drive Georgetown, SC 29440 | 843-833-3563 Yejide White Boyd, LPN | yegideb@gmail.com
Pee Dee Regional CTC Training Center ID: SC05608 1209 W Evans St Florence, SC 29501-3406 8436654671 carolinacenter@bellsouth.net http://PDCTC.COM	**Robeson Community College** 5160 Fayetteville Road Lumberton, NC 28360 Kenny Locklear rccems@robeson.edu 910-272-3407
Pee Dee Regional EMS 1314 W Darlington St Florence, SC 29501-2122 | 8436625771 Mark Self – mself@pdrems.com Until Dec. 2022 Kim Dorsett – kim@pdrems.com After Dec. 2022 www.pdrems.com http://www.pdrems.com	**Grand Strand Regional Medical Center** Class conducted at Coastal Grand Mall 2000 Coastal Grand Cir Suite 520 Myrtle Beach, SC 29577 843-839-9933 Dalena.nguyen2@hcahealthcare.com

NOTE: Remember to take the HGTC CPR/BLS Form with you so your instructor can complete it on your behalf. In addition to remitting a copy of your form immediately after your class concludes, you will also need to remit a copy of your BLS Card/Certificate within 30 days.

If you are receiving your certification through a local fire department ONLY, you can complete the online written portion of the BLS course through the American Heart Association at **www.onlineaha.org (Heart Code BLS).** Print your Part 1 Certificate once complete and contact the fire department to schedule your Part 2 Skills Assessment and Part 3 BLS Skills Testing. You must complete parts 2 and 3 within 30 days of completing AHA BLS Online part 1.

Student Health Record for Expanded Duty Dental Assisting and Dental Hygiene	Student Name: _____ Student H#_____ Program: _____

DIRECTIONS: Please print in ink or type Section I before going to your physician for examination. Be sure to answer all questions fully and include your name at the top of each page. Health information, including immunization records will be released to authorized clinical agencies with your consent (as designated by your signature on page 2). Students will not receive clearance for clinical without a complete record. Students must submit the completed "Student Health Record" prior to program matriculation. If you have questions concerning a disability, or if requesting reasonable accommodations contact Student Counseling Services at 349-5302. If requesting accommodations, you must provide appropriate medical, psychological and/or psychiatric documentation to support this request. **A copy of immunizations/titer lab results must accompany this form.**

SECTION I (to be completed by student)

Name: _____
(Last) (First) (Middle)

Other Name(s) Student Known As: _____ Birthdate: _____

Home Address: _____
(Street) (City) (State) (Zip)

Telephone: _____
(Home) (Cell) (Work)

Past Medical History: **ALLERGIES:** _____

Have you had?	Yes	No	**Have you had?**	Yes	No
Rubeola			Stomach/Intestinal Abnormality		
Rubella			Arthritis		
Mumps			Asthma		
Chicken pox (MD documented)			Hay fever		
Infectious Mono			Color blindness		
Positive TB Skin Test			Recurrent headaches		
Recurrent Herpes Viruses			Back problems		
Sexually Transmitted Disease			Organ transplant		
Heart disease			Insomnia		
Heart murmurs			Frequent Anxiety		
Mitral Valve Prolapsed			Frequent Depression		
High Blood Pressure			Worry or Nervousness		
Rheumatic fever			Hepatitis (specify: A,B,C,D,E)		
Diabetes			Epilepsy/Convulsions		
Kidney/Bladder Abnormality			Other (explain below):		

If you check any of these conditions, more information is required in the next section

Student Health Record For Expanded Duty Dental Assisting and Dental Hygiene	Student Name: _____ Student H#_____ Program: _____

If you answered "yes" to any question, please give dates and treatments:

_____

_____

Please list any other medical conditions not addressed above:

_____

Please list all medications that you are currently taking:

_____

Student Signature _____ **Date** _____

SECTION II: Physical Examination (To be completed by the physician, physician assistant, or nurse practitioner)

Directions: Please review Section I completed by the student and then complete all of the following items in Section II.

Height: _____ Weight: _____ Blood pressure: _____ Pulse: _____ Respirations: _____ Temp: _____

Corrected Vision: RIGHT: 20/ _____ Hearing: (Please circle)
LEFT: 20/ _____ RIGHT: Normal Impaired LEFT: Normal Impaired

A. Does the student have any changes and/or concerns in the following systems? (Give dates, description of change and treatment of ALL findings - see below)

System	Yes	No	System	Yes	No
Eyes			Musculoskeletal		
Ears			Metabolic/Endocrine		
Nose, throat			Genitourinary		
Neurological			Skin		
Respiratory			Immunological		
Cardiovascular (including murmurs)			Psychiatric		
Gastrointestinal			Other (please explain)		

B. If you have answered "yes" to any item in **A** above, please complete the following: (Additional information may be provided on a separate page identified with student's name).

Date	Diagnosis	Treatment	Restrictions/Limitations (Bending, lifting, pulling, etc.)

HORRY GEORGETOWN TECHNICAL COLLEGE **Student Health Record For Expanded Duty Dental Assisting and Dental Hygiene**	Student Name: _____ Student H#_____ Program: _____

ESSENTIAL FUNCTIONS REQUIRED OF STUDENTS FOR ADMISSION AND PROGRESSION IN THE

_____
(PROGRAM NAME)

TECHNICAL STANDARDS OF THE DENTAL SCIENCES DEPARTMENT

The Dental Sciences Department is comprised of the Dental Hygiene and Expanded Duty Dental Assisting programs that require specific technical standards. These standards refer to all non-academic admissions criteria essential to participate in the program. In order to be considered, admitted, or retained in the program after admission, all applicants with or without accommodations must possess the following abilities:

ESSENTIAL FUNCTIONS REQUIRED OF STUDENTS
FOR ADMISSION AND PROGRESSION IN THE DENTAL SCIENCES DEPARTMENT

Applicants/students MUST be able to perform these essential functions. For those applicants requesting reasonable accommodations such as compensatory techniques and/or assistive devices, you MUST also be able to demonstrate the ability to become proficient in these essential functions.

If your ability to perform these essential functions depends on accommodations being provided, be advised that requests for accommodations must be presented to "Disability Services", and must be accompanied by appropriate medical, psychological and/or psychiatric documentation to support this request. You may contact "Disability Services" at (843) 349-5249.

HORRY GEORGETOWN TECHNICAL COLLEGE

Student Health Record For Expanded Duty Dental Assisting and Dental Hygiene

Student Name: _____

Student H#_____

Program: _____

ESSENTIAL FUNCTION	TECHNICAL STANDARD	SOME EXAMPLES OF NECESSARY ACTIVITIES
Physical Requirements	Must have use of both hands and dexterity in the fingers; body build must fit into dental operator's stool; use of feet.	Proper manipulation of dental instruments, materials, and dental handpieces; proper manipulation of foot pedals to activate handpieces and other dental equipment.
Data Conception	Must have the ability to gather, classify, and interpret information regarding patients or things, must be able to carry out appropriate actions in relation to the data received.	Proper interpretation of data given in the medical history and coordination of patient treatment with regards to the data.
Color Discrimination	Must be able to differentiate various shades of colors in a limited environment and space in the oral cavity.	Recognition of changes in the oral cavity from normal to abnormal with regards to tissue color.
Manual Dexterity/Motor Coordination	Must have excellent eye-hand coordination and manual dexterity.	Manipulating dental instruments in a small area to discern changes in surface texture without causing tissue trauma, controlling pressure exerted by dental handpieces on dental tissue, dexterity required for instrument exchange.
Physical Communication	Must be able to perceive sound.	Talking to patients on the telephone, hearing commands through operator's face mask, discerning blood pressure sounds through a stethoscope.
Reasoning Development	Must be able to apply principles of logical or scientific thinking to define problems, collect data, establish facts, and draw valid conclusions.	Interpreting knowledge that has been learned in the classroom towards patient treatment.
Visual Acuity	Must be able to see minute, detailed shapes from a 2 foot distance.	Identification of working ends of dental instruments and other dental implements.
Language Development	Must be able to read and comprehend complex information; able to communicate the same type of information through speech and in writing.	Communication to patients of technical information in a clear concise manner at an understandable level.
Numerical Ability	Must be able to determine percentages, convert fractions, ratio, and proportions as well as basic mathematical skills.	Calculation of percentages with regards to plaque indices, counting of teeth, calculation of fees and percentages of those fees.

Student Health Record For Expanded Duty Dental Assisting and Dental Hygiene	Student Name: _____ Student H#_____ Program: _____

Form/Spatial Ability	Must be able to view in 3-dimensional relationships, distinguish subtle changes from one form or shape to another, discriminate intricate measurements.	Visualize tooth morphology during cavity preparation, documentation of probe readings during oral examination and periodontal charting.
Personal Temperament	Must be able to maintain a professional attitude and appearance, deal with stress, adapt to change, and function and focus in an environment with multiple extraneous stimuli.	Progress through a rigorous, challenging curriculum that is stressful, while maintaining a professional attitude and appearance when treating patients in an open-bay clinic or dental office setting that will have some noise and interruption.

NOTE: Students with documented disabilities through "Disability Services" of HGTC should inform their Course Professor at the beginning of each course to allow for accommodations for testing, note taking, etc.

Does the student have any restrictions/limitations?	Yes	_____	No	_____
If yes, how many weeks are restrictions/limitations in effect:				
If yes, what date will the restrictions/limitations be lifted:				
If yes, will the student be required to follow-up with your office:	Yes	_____	No	_____
If yes, date of scheduled appointment for follow-up:				

I hereby certify to the best of my knowledge that the preceding information is complete and accurate.

_____ _____

Print Name of Physician, Physician Assistant, or Nurse Practitioner Date

_____ _____

Signature of Physician, Physician Assistant, or Nurse Practitioner Date

NOTE: Some allied health programs may have additional requirements. Individual students assume responsibility for ensuring all requirements have been met according to the designated curriculum for the program of which he/she is seeking entry.

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

WAIVER OF REPEAT PHYSICAL EXAMINATION / NOTIFICATION OF CHANGE IN HEALTH STATUS

(Your initial Health Science Division – Student Health Record (form 3a) is valid for one semester. If you have had no changes in your medical history, you are eligible to complete this Waiver/Notification Form. If you have had any changes in your medical status, including new medications or any other additional change, continue reading below but do not sign this form. You are required to complete a new Health Science Division – Student Health Record (form 3a).

I, _____, as a student enrolled in a Health Science Division Program at Horry-Georgetown Technical College, do hereby declare that I have sustained no changes in my physical health condition from my most recent student health examination required for the program.

- It is my understanding that in the event a physical health change occurs, it is my responsibility to immediately notify the following individuals of such change(s):
    1. Primary Course instructor and Clinical Instructor
    2. Clinical Admissions Specialist
- Following notification of health physical change(s), it is my responsibility to:
    1. Make an appointment with a healthcare provider for physical examination and completion of a new Health Science Division – Student Health Record (form 3a).
    2. Provide completed form 3a to the Clinical Admissions Specialist for verification of current eligibility for clinical without restrictions (specifically page 3 of health record).
    3. Contact Student Affairs at (843) 349-5249 if you would like to request accommodations.
- If restrictions are indicated on the Health Record Form, the Clinical Admissions Specialist will notify the student's designated Program Coordinator for guidance regarding further clinical continuation.
- In the event I fail to notify the appropriate individuals of such health changes, Horry-Georgetown Technical College is released from all liability relevant to my physical health status, and such failed actions on my behalf may result in dismissal from the program of study and/or constitute legal action thereof.

Printed Name Signature Date

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

Purified Protein Derivative (PPD) / Tuberculin Skin Test (TST) Form or QFT Gold Blood Assay

All information must be completed or it will not be accepted. PPDs must be read within 48-72 hours of administration.

PPD	Date/Time Given	Injection Site	Lot # & Manufacturer	Expiration	Result	Induration	Date/Time Read	Initials
**Step 1 (2 visits) *AND*					❑ Negative ❑ Positive	_____mm		
**Step 2 (2 visits) *OR*					❑ Negative ❑ Positive	_____mm		
**QFT Gold Blood Assay		If you elect a QFT instead of the PPDs, you must remit a copy of the lab results.			❑ Negative ❑ Positive			

- Step 1 **and** Step 2 are required for all Allied Health programs.
- Step 2 should be administered 7 days after Step 1 has been administered and/or read. ***There is a max time frame of 21 days between Step 1 and Step 2.**
- Annual 1 Step PPD must be completed before the prior one expires.
- If PPD result is **POSITIVE** (>10 mm induration), student must provide proof of negative CXR.
- If **Positive** PPD – documentation from physician stating any further care is required.

Certification: Signature below indicates verification of above initials in administration of PPD/TST.

Signature:

_____

Signature: _____

Signature: _____

- Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

INFLUENZA FORM

(Influenza A/B; H1N1 Combination Vaccine)

Injection 1 (Lot Number): _____ Date: _____ Initials:_____

Expiration Date: _____ Manufacturer: _____ Injection Site: _____

Certification:

Signature below indicates verification of above initials in administration of, or reporting of, documented result for Influenza Immunization(s).

_____

Signature Title (MD, NP, RN)

_____

Signature Title (MD, NP, RN)

_____

Signature Title (MD, NP, RN)

- Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

Tetanus, Diphtheria, Pertussis (TDAP) Form

This form must be complete or an immunization record is needed.

Injection	Lot #	Manufacturer:	Expiration:	Injection Site:	Date	Initials
1.						
Booster						

Certification:

Signature below indicates verification of above initials in administration of TDAP immunization and/or titer result.

_____

Signature

_____

Signature

- Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

HEPATITIS B FORM

This form must be complete or an immunization record is needed.

Injection	Lot #	Manufacturer:	Expiration:	Injection Site:	Date	Initials
1.						
2.						
3.						

Or

Hepatitis B Surface Titer Result: _____ Date: _____ Initials: _____
(Must have lab results)

Or

Declination/Waiver on the next page

Certification:

Signature below indicates verification of above initials in administration of Hepatitis B immunization and/or titer result.

_____

Signature

_____

Signature

_____

Signature

- Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.
- Titer result may be reported on this sheet but must be accompanied by lab result with reference range clearly designated.

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

MANDATORY HEPATITIS B VACCINE SERIES IN PROGRESS OR DECLINATION

Instructions:

Check the appropriate box(es) to indicate your compliance with the Hepatitis B requirement.

SERIES IN PROGRESS

❑ * I am in the process of receiving the Hepatitis B Vaccine and will provide documentation of all vaccinations as they are completed. Until I am fully vaccinated, I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection.

DECLINATION

❑ I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been informed of the opportunity to be vaccinated with Hepatitis B Vaccine. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I will decide at that time.

_____

Student Signature H# Date

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

MEASLES, MUMPS, RUBELLA (MMR) FORM

IgG TITERS ARE REQUIRED

Titer results must be accompanied by actual lab results with scores and reference ranges clearly designated.

MEASLES Titer Result: _____ Date: _____ Initials: _____

MUMPS Titer Result: _____ Date: _____ Initials: _____

RUBELLA Titer Result: _____ Date: _____ Initials: _____

- If you previously completed the 2-dose vaccine and any of your current titers are **NEGATIVE** or **EQUIVOCAL**, you are required to receive a 1-dose booster vaccine immediately. Documentation for the initial 2-dose vaccine and negative titers results must also be remitted.
- If you did not previously complete the 2-dose vaccine and your current titers are **NEGATIVE** or **EQUIVOCAL**, you are required to receive the following immunizations:
    - If all 3 MMR or Measles or Mumps are **NEGATIVE** or **EQUIVOCAL**: Two (2) doses of MMR are required.
    - If Rubella is **NEGATIVE** or **EQUIVOCAL**: One (1) dose of MMR is required.

Injection	Lot #	Manufacturer:	Expiration:	Injection Site:	Date	Initials
1.						
2.						

Certification:

Signature below indicates verification of above initials in administration of MMR immunization and/or titer result.

_____

Signature Title (MD, NP, RN)

_____

Signature Title (MD, NP, RN)

- Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

VARICELLA (CHICKENPOX) FORM

IgG TITERS ARE REQUIRED

Titer results must be accompanied by actual lab results with scores and reference ranges clearly designated.

VARICELLA Titer Result: _____ Date: _____ Initials: _____

- If you previously completed the 2-dose vaccine and your current titers are **NEGATIVE** or **EQUIVOCAL**, you are required to receive a 1-dose booster vaccine immediately. Documentation for the initial 2-dose vaccine and negative titers results must also be remitted.
- If you did not previously complete the 2-dose vaccine and your current titers are **NEGATIVE** or **EQUIVOCAL**, you are required to receive the 2-dose vaccine beginning immediately.
- Physician documented history of Varicella will not be accepted as proof of immunity.

Injection	Lot #	Manufacturer:	Expiration:	Injection Site:	Date	Initials
1.						
2.						

Certification:

Signature below indicates verification of above initials in administration of Varicella immunization and/or titer result.

_____

Signature Title (MD, NP, RN)

_____

Signature Title (MD, NP, RN)

- Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.

PROFESSIONAL LIABILITY INSURANCE

Required for the following Allied Health Programs

Computerized Axial Tomography	Phlebotomy (AHS 167)
Dental Assistant (DAT)	Physical Therapy Assistant (PTH)
Dental Hygienist (DHG)	Practical Nursing (LPN/PNR)
Diagnostic Medical Sonography	Radiology Technology
EMT – Basic / Intermediate	Registered Nurse (NUR/ADN)
Medical Lab Technology	Respiratory Care
Occupational Therapy Assistant	Surgical Technology
Paramedic	Vascular Sonography
Patient Care Medical Technician (AHS 163)	

If you change programs, your specialty must be changed on your policy.
Example, if you are a DAT student in the spring and then go into the DHG program for fall, the specialty on your policy must be changed from dental assistant to dental hygienist.

Students may choose a vendor of their choice; however, coverage amounts must be as stated as below.

One 3rd party vendor is Healthcare Providers Service Organization (HPSO)
www.hpso.com – 1-800-982-9491

On the HPSO website, click "Get a Quote" > Select "Students" and "Get Started" > Follow the prompts as a "Student"

Minimum Coverage: $1,000,000 each claim and $3,000,000 aggregate

You will receive an email confirming your application was submitted.

Within 24-48 hours, you will receive an email containing your actual Policy.
We will need the **Certificate of Liability** for proof, not a copy of the application or proof of payment.

As of 09/29/2022, the Annual Premium was $44.10. Prices are subject to change

Immunization Cost Estimates for Students
WITHOUT Health Insurance Coverage
Some of these ARE covered under most health insurance plans

DISCLAIMER: This information is to be used as a guide only, as it is subject to change. HGTC cannot be held responsible for the prices listed below. It is the student's responsibility to call and confirm availability, pricing, and insurance requirements. HGTC is not affiliated with any of these providers regarding provision of healthcare services and is unable to recommend any specific provider.

You do not have to use these providers. YOU MAY USE YOUR OWN PROVIDER.

The prices below are from September 2022. They are subject to change. Call ahead for pricing.

Immunization	Care Now 843-626-2273 (7 Locations)	Carolina Health Pharmacy 843-215-8200	CVS Minute Clinic 866-389-2727	Doctor's Care 843-238-1461	South Strand Internist and Urgent Care 843-945-3030	Little River Medical Center 843-663-8000 Call far ahead for appointments	Palmetto Express Clinic 843-750-0324	Southern Urgent Care 843-357-4357
Office Visit Fee	$50 + Cost of Services Below	NA	NA	$135.00	$80	Sliding Scale	$65.00	$130.00
Vaccine Admin. Fee	$52.00	NA	NA	NA	$17.50	Sliding Scale	NA	$50.00
Tuberculin Skin Testing (PPD) x 1 OR *QFT Gold Blood Assay	$23.00 (PPD) $120.00 (QFT)	NA	$74.00	$34.00 $60.00 (QFT)	$19.00	Sliding Scale	$25.00 (PPD) $100 (QFT)	$45.00 (PPD) $110.00 (QFT)
Chest X-Ray with Positive PPD	$56.00	NA	NA	$90.00	$31.20 - $98.80	Sliding Scale	NA	$100.00
MMR Titer	$109.00	NA	$99 - $139	$74 each +$51 stick fee	NA	Sliding Scale	$60.00	$50.00
Varicella Titer	$35.00	NA	$99 - $139	$85.00	NA	Sliding Scale	$30.00	$50.00
Hep B Titer	$41.00	NA	$99 - $139	$100.00	NA	Sliding Scale	$30.00	$30.00
MMR Vaccine x 1	$115.00	$115.00	$135.00	$100.00	$100.00	Sliding Scale	NA	NA
Hep B Vaccine x 1	$25.00	$92.00	$145.00	$104 (each) (Dynavax) $156 (2-dose)	$58.00	Sliding Scale	NA	NA
Varicella Vaccine x1	NA	NA	$166.00	NA	$172.00	Sliding Scale	NA	NA
TDAP (Adacel) Vaccine	$60.00	$64.00	$95.00	$71.00	$43.55	Sliding Scale	NA	$75.00
Flu	$20.00	$35.00	$50.00	$40.00	$19 - $26	Sliding Scale	$35.00	NA

For students who meet certain income guidelines, some services are provided at low or no cost through **the SC Health Departments**. Call (855) 472-3432 to make an appointment at any of these locations.

- Myrtle Beach Health Dept, 21st Ave, Myrtle Beach (843) 448-8407
- Conway Health Dept., Industrial Park Road, Conway (843) 915-8800
- Stephen's Crossroad Health Dept., Hwy 57 North, Little River (843) 915-5654
- Georgetown County Public Health Department, Lafayette Cir, Georgetown (843) 546-5593

HORRY GEORGETOWN TECHNICAL COLLEGE Health Science Division – Student Health Record	Student Name: _____ Student H#_____ Program: _____

CHEST X-RAY FORM

(Required with 1st time positive PPD)

CXR Date: _____ Result: _____ Initials: _____

NOTE: Copy of actual result must be attached. CXR result is valid for two (2) years.

If CXR is **NEGATIVE,** student must complete a SYMPTOM ASSESSMENT FORM (form 4c).

If CXR is **POSITIVE**, student will be referred to DHEC for treatment (if applicable) according to DHEC guidelines. Clearance from primary care provider is required for return to clinical setting if student was referred for positive CXR.

Certification:

Signature below indicates verification of above initials in administration of/and reporting result of CXR.

_____

Signature Title (RN, NP, MD)

_____

Signature Title (RN, NP,MD)

_____

Signature Title (RN, NP, MD)

- Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

SYMPTOM ASSESSMENT FORM

Required Yearly

Instructions:

*Complete this form **ONLY** if you had a Positive (+) Tuberculin Skin Test with a Negative (-) CXR.*

Date: _____ Date of Positive PPD: _____ Date of Negative CXR: _____

Have you been treated with tuberculosis medication?	❑ Yes	❑ No
Have you ever received a BCG (tuberculosis vaccine)?	❑ Yes	❑ No
Have you been exposed to an isolated case of TB this year?	❑ Yes	❑ No

Do you have any of the following?

• Productive cough (≥ 3 weeks)	❑ Yes	❑ No
• Persistent weight loss without dieting	❑ Yes	❑ No
• Persistent low-grade fever	❑ Yes	❑ No
• Night sweats	❑ Yes	❑ No
• Loss of appetite	❑ Yes	❑ No
• Swollen glands in the neck	❑ Yes	❑ No
• Recurrent kidney or bladder infections	❑ Yes	❑ No
• Coughing up blood	❑ Yes	❑ No
• Shortness of breath	❑ Yes	❑ No
• Chest pain	❑ Yes	❑ No

If you answered "YES" to any of the above questions, please explain:

_____

_____

_____

(Note: Clearance from a primary care provider, which may include repeat CXR, is required prior to clinical attendance if you answered "YES" to any of the above questions).

Student's Signature: _____ Date: _____

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

VACCINE ALLERGY/WAIVER FORM

Vaccine	Contraindication to student receiving vaccine:	Initials
❑ TST/PPD ❑ Influenza ❑ TDAP ❑ Hepatitis B ❑ MMR ❑ Varicella	❑ Documented Allergy to Vaccine or Component of Vaccine *Additional information required below* ❑ **Pregnancy** EDC: _____ • Must be for live virus vaccine • Date Vaccine can safely be administered _____ ❑ Currently Immunosuppressed/Immunocompromised • Disease/Condition: _____ • Date Vaccine can be safely be administered _____	

If requesting a Medical Exemption, please have your medical provider (MD, DO, APRN, or PA) complete and sign below.

[ ] Anaphylaxis [ ] Guillain-Barré Syndrome [ ] Other Severe Reaction or medical condition:

Please specify reaction/condition: _____

_____

_____

_____

Certification:

Signature below indicates **verification of above initials** in reporting of valid contraindication for student not receiving designated vaccine.

_____

Provider Name Provider Address Provider Phone Number

_____

Signature Title (MD, NP, PA)

_____