Health Tracker Clinical Requirements

for

Computerized Axial Tomography
Diagnostic Medical Sonography
Health Care Certificate
Medical Laboratory Technology
Nursing
Occupational Therapy Assistant
Paramedic
Patient Care Medical Assistant
Phlebotomy
Physical Therapy Assistant
Radiologic Technology
Respiratory Care
Surgical Technology
Vascular Sonography
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Remit transcript showing all completed modules with your name & dates.

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Must be BLS (Basic Life Support) Certificate through the AHA or ARC ONLY

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All boxes must be checked on page 1 and 2. Be sure you sign and date page 2.
Your physician needs to complete the bottom of page 2 and page 3.

Section 4 PPD or QFT Gold Blood Assay ..................................................................... 12
A 2-step PPD is 4 visits. After the initial 2-step or QFT, a 1-step (2 visits) or QFT is required yearly.

Section 5 Vaccinations:

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Immunization Cost Estimate Sheet
Positive PPD – Symptom Assessment Form
Vaccine Allergy Waiver
Clinical Requirements Checklist*

- Criminal Background Check – see CBC/UDS/HT Instructional Packet
- Urine Drug Screening – see CBC/UDS/HT Instructional Packet
- Castle Branch Compliance Tracker – see CBC/UDS/HT Instructional Packet
- GHO Care Learning Modules Transcript
- BLS CPR Certification
- Health Physical completed on HGTC 4-page forms.
- 2 Step PPD or QFT Gold Blood Assay
- Seasonal Flu Vaccine (not required for the summer semester)
- COVID Vaccine Card if you have one or answer No in your CB Tracker
- Tdap Vaccine
- Hepatitis B 3- or 2-dose series or Titer or Declination Waiver
- MMR 2 doses or Titer Lab Results showing your scores with the reference ranges.
- Varicella 2 doses or Titer Lab Results showing your score with the reference range.
- Liability Insurance Certificate
- Clinical Forms and Disclosures
- Photo to be taken in the Clinical Admissions Office, Speir Bldg., room 1209

*This checklist is for all Nursing and Health Science Students except Dental Hygiene, Dental Assisting, EMT Basic and Massage Therapy.
IMPORTANT NOTES

- Any requirement 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 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 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 is positive**, a PPD symptom assessment form must be completed **yearly**.

- **The Seasonal Flu vaccine** is not required for the Summer Semester. It is required for Fall and Spring semesters.
- **The COVID vaccine** is not mandatory to attend HGTC. If you received ANY COVID vaccinations, please upload your card or proof. If you have not received any doses, please answer No in your Castle Branch tracker.

- **Hepatitis B**: There are 4 options to choose from.
  - **Option 1 – Proof of Hepatitis B Immunizations**: Provide a copy of your immunization record showing you received the Hepatitis B series. This can be from a childhood, school or military immunization record.
  - **Option 2 – Reactive Hepatitis B Surface Antibody Titer**: Provide a copy of the Hepatitis B surface antibody titer lab results showing you are immune to Hepatitis B. If your titer is **NONREACTIVE**, you must receive a booster with proof of a prior immunization record OR go to Option 4 and complete the declination. If an immunization record is not available, you must receive the series OR go to Option 4 and complete the Declination.
  - **Option 3 – Series in Progress**: Start the 3-dose series, with the 1st dose now, 2nd dose in one month, 3rd dose should be five months after the 2nd dose. There is also a 2-dose series available which is 4 weeks apart (Dynavax /Heplisav-B).
  - **Option 4 – Declination Waiver**: You may opt out. Please see the Hepatitis Declination Waiver on page 16. Check the second box, sign & date.

- **MMR and Varicella**: There are 2 options to choose from.
  - **Option 1 – Proof of MMR and Varicella Immunizations**: Provide a copy of your immunization or medical record showing you received 2 MMR and 2 varicella doses. This can be from childhood, school or military records.
  - **Option 2 – MMR and/or Varicella IgG Titer**: Measles, mumps, rubella and varicella titers are only recommended if there is no proof of the vaccination history, but the student is certain they received the vaccines in the past. Positive results mean you are immune, and no additional vaccines or testing are required. Negative titer results (non-immune) may require re-vaccination, with no repeated titers required.

- **Liability Insurance** – The Certificate of Liability must be submitted. A copy of the application or proof of payment will be rejected. 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.
Completing the below Care Learning modules expedites the orientation process and facilitates the completion of basic regulatory training requirements prior to entering a healthcare facility. To get started, create a new account or re-use your existing account at: http://passport.carelearning.com.

- Use your school issued HGTC email account when creating your Care Learning account. The program will require you to verify your account during the process.
- You will purchase courses and have access to them for 365 days. The total cost is $15.00. The modules must be completed yearly unless they expire during the semester. If so, you will click on Repurchase to complete the updated modules again prior to the start of the semester.

- Below are the 28 modules that must be completed for HorryGeorgetown Technical College.
- When you Enter the Classroom, you MUST manually ADD these 3 modules by clicking Add Courses:
  - MUSC Health Florence, Marion, Black River Orientation
  - Tidelands, Conway, Grand Strand, Waccamaw (GHO)
  - Tidelands – Ebola Preparedness

<table>
<thead>
<tr>
<th>Abuse, Neglect, and Exploitation</th>
<th>Lewis Blackman Patient Safety Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDET</td>
<td>Moving, Lifting and Repetitive Motion</td>
</tr>
<tr>
<td>Bloodborne Pathogens</td>
<td>MUSC-Florence, Marion, Black River Orientation</td>
</tr>
<tr>
<td>COVID-19: Coronavirus Disease 2019</td>
<td>Pain Management</td>
</tr>
<tr>
<td>Culturally Competent Care</td>
<td>Patients Rights</td>
</tr>
<tr>
<td>Customer Service</td>
<td>Population Specific Care: Pediatric</td>
</tr>
<tr>
<td>Electrical Safety</td>
<td>Population Specific Care: The Adult Patient</td>
</tr>
<tr>
<td>Emergency Preparedness</td>
<td>Sexual Harassment</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>Slips, Trips, and Falls</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>TB Prevention</td>
</tr>
<tr>
<td>Hazard Communications</td>
<td>Tidelands Health - Ebola Preparedness</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Tidelands, Conway, Grand Strand, Waccamaw – (GHO)</td>
</tr>
<tr>
<td>Infection Prevention and Control for Non-Clinical Employees</td>
<td>Workplace Diversity</td>
</tr>
<tr>
<td>Isolation and Standard Precautions</td>
<td>Workplace Violence Prevention</td>
</tr>
</tbody>
</table>

- When all modules are complete, please upload a copy of your transcript to your Castle Branch tracker.

- If you need technical support, call 866-617-3904 or email support@carelearning.com Monday-Friday 8am-6pm.
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

<table>
<thead>
<tr>
<th>CPR Completion Date:</th>
<th>Certifying Agency:</th>
<th>Instructor’s Initials:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ AHA</td>
<td>□ ARC</td>
</tr>
</tbody>
</table>

Certification:
☐ Yes, this student completed the **BLS CPR Certification for Healthcare Providers** through AHA or ARC.

---

Instructor Printed Name  
Instructor Signature  
Date

CPR Instructor Affiliation ____________________________________________

**NOTE:** If you are not receiving your CPR card/certificate the day of your class, please take this HGTC CPR BLS form with you so your instructor can complete it on your behalf. This form is valid for 30 days. You will need to remit a copy of your BLS CPR card/certificate within 30 days after your class.

To retrieve your card online from the American Heart Association, go here - [https://ecards.heart.org/student/myecards](https://ecards.heart.org/student/myecards)

To retrieve your card online from the American Red Cross, go here - [https://www.redcross.org/take-a-class/digital-certificate](https://www.redcross.org/take-a-class/digital-certificate)
**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

<table>
<thead>
<tr>
<th>Horry-Georgetown Technical College – Workforce Development – Courtney Sterbenz, Program Manager</th>
<th>Horry County Fire &amp; Rescue</th>
</tr>
</thead>
</table>
| Cost: $165.00 (Scholarships are available)  
950 Crabtree Lane, Building 600, Rm 631  
Myrtle Beach, SC 29577  | 2560 Main St Suite 1  
Conway, SC 29526  |
| 843-477-2020 OR 843-477-2079 | 843-915-5190  
Melissa Rabonbrownm@horrycountysc.gov |
| Dates of CPR classes can be found at [www.hgtc.edu/jobtraining](http://www.hgtc.edu/jobtraining) under Allied Health. | Cost: Online Portion - $32.50 - [www.onlineaha.org](http://www.onlineaha.org)  
In Person Skills - $15  
[www.horrycountyfirerescue.com/training](http://www.horrycountyfirerescue.com/training) |

<table>
<thead>
<tr>
<th>Bless Your Heart - CPR</th>
<th>Andy Brown</th>
</tr>
</thead>
</table>
| Cost: $45.00 (Materials Included)  
843-457-3305  
holly.wittschen@yahoo.com | Cost: $65  
843-957-0124  
ambrownl2345@gmail.com |
| Holly Wittschen | Myrtle Beach Area  
843-545-3627 OR 843-267-2300  
cgilmore@gtcounty.org OR mfdbc82@gmail.com  
[http://www.midwayfirerescue.org](http://www.midwayfirerescue.org) |

| Midway Fire Department | Shannon & Greg Raxter  
Carolina Hartsavers |
|---|---|
| Battalion 82 Training Solutions, LLC  
Pawleys Island / Litchfield Area  
843-545-3627 OR 843-267-2300  
cgilmore@gtcounty.org OR mfdbc82@gmail.com  
843-333-8705  
snraxter@gmail.com |

<table>
<thead>
<tr>
<th>Pee Dee Regional CTC</th>
<th>Robeson Community College</th>
</tr>
</thead>
</table>
| Training Center ID: SC05608  
11209 W Evans St  
Florence, SC 29501-3406  | 5160 Fayetteville Road  
Lumberton, NC 28360  |
| 8436654671 carolinacenter@bellsouth.net  
[http://PDCTC.COM](http://PDCTC.COM) | Kenny Locklear  
rcems@robeson.edu  
910272-3407 |

<table>
<thead>
<tr>
<th>Pee Dee Regional EMS</th>
<th>Grand Strand Regional Medical Center</th>
</tr>
</thead>
</table>
| 1314 W Darlington St  
Florence, SC 29501-2122  | Class conducted at Coastal Grand Mall  
2000 Coastal Grand Cir Suite 520  
Myrtle Beach, SC 29577  |
| 8436654671 kim@pdrems.com  
[www.pdrems.com](http://www.pdrems.com)  
[http://www.pdrems.com](http://www.pdrems.com) | 843-839-9933  
Dalena.nguyen2@hcahealthcare.com |

All students must be Basic Life Support (BLS) CPR Certified through the American Heart Association (AHA) or American Red Cross (ARC). Certification is offered in two (2) formats, Blended Learning and an all In Person Classroom Training. For the blending learning, the first portion is completed online. Then the second portion, the hands-on skills assessment, MUST be completed in person. If you select one of the vendors above, their class may be the all In Person Classroom Training. Therefore, check with the instructor FIRST before purchasing the online portion.

**NOTE:** If you are not receiving your CPR card/certificate the day of your class, please take the HGTC CPR/BLS Form with you so your instructor can complete it on your behalf. The form is valid for 30 days. You will need to remit a copy of your BLS CPR card/certificate within 30 days after your class.
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.

**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)

**Medical History:**

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

If you check any of these conditions, more information is required in the next section.
If you checked “Yes” to any medical history on the previous physical page, 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 below)

<table>
<thead>
<tr>
<th>System</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nose, throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
<td></td>
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<tr>
<td>Cardiovascular (including murmurs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
<td></td>
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<tr>
<td>Metabolic/Endocrine</td>
<td></td>
<td></td>
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<tr>
<td>Genitourinary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunological</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please explain)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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).

<table>
<thead>
<tr>
<th>Date</th>
<th>Diagnosis</th>
<th>Treatment</th>
<th>Restrictions/Limitations (Bending, lifting, pulling, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ESSENTIAL FUNCTIONS REQUIRED OF STUDENTS FOR ADMISSION AND PROGRESSION
IN THE NURSING AND HEALTH CARE SCIENCE PROGRAMS

The following standards are considered essential criteria for participation in the Nursing and Health Science Programs. Students selected for Nursing or one of the Health Science programs must be able to independently engage in educational activities and clinical training activities in a manner that will not endanger clients/patients, other students, staff members, themselves, or the public. These criteria are necessary for the successful implementation of the clinical objectives of the Nursing and Health Science Programs. In order to be admitted, or to be retained in the Nursing or one of the Health Science Programs after admission, all applicants with or without accommodations must:

➢ Possess sufficient visual acuity to independently read and interpret the writing of all size.

➢ Independently be able to provide verbal communication to and receive communication from clients/patients, members of the health care team, and be able to assess care needs through the use of monitoring devices, stethoscopes, infusion pumps, fire alarms, and audible exposure indicators, etc.

➢ Possess sufficient gross and fine motor skills to independently position and assist in lifting client/patients, manipulate equipment, and perform other skills required in meeting the needs of nursing care.

➢ The student (Observer) is free of communicable illnesses.

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

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

______________________________
Signature of Physician, Physician Assistant, or Nurse Practitioner

Office if Applicable

Date

NOTE: Some NURSING AND HEALTH SCIENCE 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.
WAIVER OF REPEAT PHYSICAL EXAMINATION / NOTIFICATION OF CHANGE IN HEALTH STATUS

Your initial Health Science Division – Student Health Physical Record is valid for one year. 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, you are required to complete a new Health Science Division – Student Health Physical Record.

I, ________________________________, as a student enrolled in a Nursing or Health Science 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 Office

- 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 Physical Record.
  2. Provide the completed Student Health Physical Record to the Clinical Admissions Office for verification of current eligibility for clinical without restrictions (specifically page 3 of health physical).
  3. Contact Student Affairs at (843) 349-5249 if you would like to request accommodations.

- If restrictions are indicated on the Student Health Physical Record, the Clinical Admissions Office will notify the student’s designated Program Department Chair and/or Dean 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.

______________________________  ________________________________  ________________
Student Printed Name          Student Signature          Date
Tuberculosis Screening

HGTC students are initially required to complete a 2-Step PPD, which consists of two tuberculin skin tests (4 office visits) OR a Quantiferon (QFT) Gold Blood Assay, which is a blood draw to test for Tuberculosis. A 1-Step PPD or QFT Gold Blood Assay is required yearly after the initial process is completed within the same one year.

If you elect to have the Quantiferon (QFT) Gold Blood Assay, submit a copy of the lab results.

If you elect to have the tuberculin skin test(s), the below section is **TO BE FULLY COMPLETED BY A HEALTHCARE PROVIDER:**

<table>
<thead>
<tr>
<th>1st Step – Visit 1:</th>
<th>1st Step – Visit 2:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Administered:</td>
<td>Date Administered:</td>
</tr>
<tr>
<td>Time:</td>
<td>Time:</td>
</tr>
<tr>
<td>Site: (please circle) Left FA Right FA</td>
<td>Results: (please circle) Negative Positive</td>
</tr>
<tr>
<td>Lot#: Expiration Date:</td>
<td>Induration: mm</td>
</tr>
<tr>
<td>Healthcare Provider Signature test was administered:</td>
<td>Healthcare Provider Signature test was read:</td>
</tr>
</tbody>
</table>

**Your PPD must be read within 48-72 hours.**

<table>
<thead>
<tr>
<th>2nd Step - Visit 3:</th>
<th>2nd Step – Visit 4:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Administered:</td>
<td>Date Administered:</td>
</tr>
<tr>
<td>Time:</td>
<td>Time:</td>
</tr>
<tr>
<td>Site: (please circle) Left FA Right FA</td>
<td>Results: (please circle) Negative Positive</td>
</tr>
<tr>
<td>Lot#: Expiration Date:</td>
<td>Induration: mm</td>
</tr>
<tr>
<td>Healthcare Provider Signature test was administered:</td>
<td>Healthcare Provider Signature test was read:</td>
</tr>
</tbody>
</table>

**Your PPD must be read within 48-72 hours.**

**Step 2 should be administered 7-21 days after Step 1 was administered.**

*There is a max time frame of 21 days between Step 1 and Step 2*

- If the QFT or PPD result is **POSITIVE** (>10 mm induration), a student must have a medical assessment, provide TB results, proof of negative CXR and complete the symptom assessment form.

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

The seasonal flu vaccine is required for the Fall and Spring semesters. It is not required for the Summer semester. It typically is available every August and will be due in September.

<table>
<thead>
<tr>
<th>Lot #</th>
<th>Manufacturer:</th>
<th>Expiration:</th>
<th>Injection Site:</th>
<th>Date</th>
<th>Initials</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Healthcare Provider Signature</th>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
</table>

Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.
Tetanus, Diphtheria, Pertussis (TDAP) Form

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

<table>
<thead>
<tr>
<th>Lot #</th>
<th>Manufacturer:</th>
<th>Expiration:</th>
<th>Injection Site:</th>
<th>Date</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

Certification:

Signature below indicates verification of above initials in administration of TDAP immunization.

<table>
<thead>
<tr>
<th>Healthcare Provider Signature</th>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
</table>

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

Option 1 – Proof of prior Hepatitis B Immunization: Provide a copy of your immunization record showing you received the Hepatitis B series. This can be from a childhood, high school or military immunization record.

Option 2 – Reactive Hepatitis B Surface Antibody Titer: Provide a copy of the Hepatitis B surface antibody titer lab results showing you are immune to Hepatitis B. If your titer is NONREACTIVE, you must receive a booster with proof of a prior immunization record. If an immunization record is not available, you must receive the series OR go to Option 4 and complete the Declination.

Option 3 – Series in Progress: If you elect to receive the series, please circle which series:

- 3-dose series
- 2-dose series
- 1 booster

(Will include prior immunization record with this form)

You MUST also check the Series in Progress box below and sign with your signature and date.

This form must be complete or an immunization record is required. “Historical” with the dates will not be accepted.

<table>
<thead>
<tr>
<th>Injection</th>
<th>Lot #</th>
<th>Manufacturer:</th>
<th>Expiration:</th>
<th>Injection Site:</th>
<th>Date</th>
<th>Healthcare Provider Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
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</tr>
<tr>
<td>3.</td>
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</tr>
</tbody>
</table>

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.

Student Signature  H#  Date

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

Option 4 – Declination Waiver:

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
MEASLES, MUMPS, RUBELLA (MMR) and VARICELLA (CHICKENPOX) FORM

Option 1 – Proof of MMR and Varicella Immunizations: Provide a copy of your immunization or medical record showing you received 2 MMR and 2 varicella doses. This can be from childhood, school or military records.

Option 2 – MMR and/or Varicella IgG Titer: Measles, mumps, rubella and varicella titers are only recommended if there is no proof of the vaccination history, but the student is certain they received the vaccines in the past.

- Positive results mean you are immune, and no additional vaccines or testing are required.
- Negative titer results may require revaccination, with no repeated titers required.

To be completed by a healthcare provider ONLY if your titer lab results show non-immunity or if you are receiving the series. Please do NOT record historical vaccinations here.

<table>
<thead>
<tr>
<th>Injection</th>
<th>Lot #</th>
<th>Manufacturer:</th>
<th>Exp Date:</th>
<th>Injection Site:</th>
<th>Date</th>
<th>Healthcare Provider Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR #1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR #2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(without prior immunization record)

<table>
<thead>
<tr>
<th>Injection</th>
<th>Lot #</th>
<th>Manufacturer:</th>
<th>Exp Date:</th>
<th>Injection Site:</th>
<th>Date</th>
<th>Healthcare Provider Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicella #1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella #2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(without prior immunization record)

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

An additional titer is not required.
PROFESSIONAL LIABILITY INSURANCE

Required for the following Nursing and Health Science Programs

<table>
<thead>
<tr>
<th>Computerized Axial Tomography</th>
<th>Phlebotomy (AHS 167)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Assistant (DAT)</td>
<td>Physical Therapy Assistant (PTH)</td>
</tr>
<tr>
<td>Dental Hygienist (DHG)</td>
<td>Practical Nursing (LPN/PNR)</td>
</tr>
<tr>
<td>Diagnostic Medical Sonography</td>
<td>Radiology Technology</td>
</tr>
<tr>
<td>Medical Lab Technology</td>
<td>Registered Nurse (NUR/ADN)</td>
</tr>
<tr>
<td>Occupational Therapy Assistant</td>
<td>Respiratory Care</td>
</tr>
<tr>
<td>Paramedic</td>
<td>Surgical Technology</td>
</tr>
<tr>
<td>Patient Care Medical Technician (AHS 163)</td>
<td>Vascular Sonography</td>
</tr>
</tbody>
</table>

If you change programs, your specialty must be changed on your policy.

Example, if you are a Phlebotomy student during the spring semester and then go into the Radiology program for the summer semester, your policy must be changed from Phlebotomist to Radiology Technologist.

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.
Clinical Forms & Disclosures

Click on your program below to access the required clinical forms and disclosures. Be sure to enter your full name and use your @hgtc.edu email account only.

The system will automatically send us a copy of your completed forms.
You do not need to email us stating they are complete.
You will have the option to download or print the completed forms for your records.

**When entering your birthdate on the forms, you may manually enter your DOB by entering MM/DD/YEAR or you may click on the year to select your birth year, then the month and day.

Diagnostic Medical Sonography / Vascular Sonography
Health Care Certificate / Patient Care Medical Assistant
Medical Laboratory Technology
Nursing ADN & PN
Occupational Therapy Assistant
Paramedic
Phlebotomy
Physical Therapist Assistant
Radiologic Technology / Computerized Axial Tomography
Respiratory Care
Surgical Technology

If you experience any issues while completing the forms, please contact us at hgtc-clinical@hgtc.edu.
Immunization Care Now
843-626-2273
(7 Locations)
CVS Minute
Clinic
866-389-2727
Doctor’s
Care
843-238-1461
South
Strand
Internist &
Urgent Care
843-945-3030
**McLeod
Health
Carolina
Forest
843-646-8400
BraVa
Health
843-750-0324
Southern
Urgent
Care
843-357-4357
Office Visit Fee
$180.00
NA
$150.00
$95 - $171
NA
$80.00
$130.00
Physical – Included
in Office Fee
180.00
$75.00 - $100.00
$100.00
$80.00
$50.00
$80.00
$45.00
Tuberculin Skin
Testing (PPD) x 1
$75.00 (PPD)
$74.00 - $139.00
(PPD)
$100.00 (QFT)
$34.00
$60.00 (QFT)
$19.00
$112.00 (QFT)
$10.00 (1 PPD)
$25.00 (PPD)
$35.00 (PPD)
$100 (QFT)
$110.00 (QFT)
Chest X-Ray with
Positive PPD
$235.00
NA
$75.00 - $90.00
$31.20 - $98.80
NA
$100.00
MMR IgG Titer
$110.00
$99 - $139
$100.00
NA
$14.75 for
MMRV
$60.00
$50.00
Varicella IgG Titer
$17.00
$99 - $139
$100.00
NA
$6.50
$30.00
$30.00
Hep B Surface Titer
$41.00
$99 - $139
$100.00
NA
$6.50
$30.00
$30.00
MMR Vaccine x 1
$110.00
$143.00
NA
$100.00
$105.00
NA
NA
Hep B Vaccine 2
Dose / 3 Dose
2 Dose - $165.00 ea
3 Dose - $95.00 ea
Admin Fee - $52.00
$153.00 ea
2 Dose $175 w
admin fee
$150 ea w
admin fee
2 Dose - $122.50 ea
3 Dose - $60.00 ea
$172.00
$200.00
NA
NA
Varicella Vaccine x1
NA
$229.00 ea
NA
$172.00
$200.00
NA
NA
TDAP (Adacel) Vaccine
$75.00
$103.00
$71.00
$45.00
$58.00
$25.00
$75.00
Flu
$20.00
$75.00 - $100.00
$40.00
$37.00
$25.00
NA
NA

**If visiting Mcleod Health (listed above), you must make an appointment & inform them you are an HGTC student to receive these prices. Be sure to show them your student ID at your appt.**

These offices offer pricing on a sliding scale:
- Little River Medical Center, Little River, SC 843-663-8000

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
SYMPTOM ASSESSMENT FORM – Required ONLY with Positive TB Test
(Required Yearly)

Instructions:
Complete this form ONLY if you had a Positive (+) Tuberculosis 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: ______________
# VACCINE MEDICAL WAIVER FORM

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Contraindication to student receiving vaccine:</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>TST/PPD</td>
<td>Dotted Allergy to Vaccine or Component of Vaccine Brackets required below.</td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TDAP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Pregnancy** EDC: __________

- Must be for live virus vaccine.
- Date Vaccine can safely be administered __________

**Currently Immunosuppressed/Immunocompromised**

- Disease/Condition: __________
- Date Vaccine can be safely administered __________

*If requesting a Medical Exemption, please have your physician 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: Must be signed by a MD or DO

Date: 

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