HORRY GEORGETOWN TECHNICAL COLLEGE

HGTC Health Science
Clinical Requirements

for

Emergency Medical Technology - **Basic**

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STUDENT NAME: _____ **PROGRAM:** **EMT - Basic**

		Clinical Requirements Checklist Any item that will expire during a semester must be completed before the semester begins.	Renewal Interval	Date Obtained	Expiring Date
☐	1.	**CPR – Healthcare Provider BLS (Basic Life Support)** ☐ CPR Card Certified through AHA or ARC ONLY	2 Years		
☐	2.	**HGTC Health Science Student Health Record – Physical** Page 1. Student Section Page 2. Student Signature & HCP Section Page 3. Essential Functions w/ HCP Signature	Initial		
☐		**Physical Waiver** - *ONLY if there are no medical changes	1 Year		
☐	3.	**Initial Tuberculin Skin Test** PPD 2 Step **OR** QFT Gold Blood Assay PPD 2 Step (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
☐		**Annual Tuberculin Skin Test** PPD 1 Step **OR** QFT Gold Blood Assay PPD 1 step (2 visits) Step 1 Administered ☐ Step 1 Read ☐- ☐+ **OR** QFT Gold Blood Assay Lab Results ☐- ☐+	1 Year Step 1 Read: QFT Date:		
☐		IF PPD is Positive, Chest x-ray (CXR) is required - Need Physician documentation Chest x-ray result (CXR) ☐- ☐+	2 Years CXR Date:		
☐		IF PPD is Positive, complete the Symptom Assessment form	Every Semester PPD-SA Date:		
☐	4.	**Hepatitis B** Prior Hep B vacs can be used (i.e. Military, childhood records) ☐ Declination Form **OR** TITER Result: ☐- ☐+ **OR** ☐ 3 Series Immunizations Dose 1= now Dose 2=1 month after dose 1 Dose 3=5 months after dose 2	Initial Dose 1: Dose 2: Dose 3:		NA
☐	5.	**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, you must renew your certificate before classes start in January.
- You may bring your documents to Clinical Admissions Coordinator's office located in the Speir Building or email them to hgtc-clinical@hgtc.edu . If you email, all documents must be one sided, legible and submitted as a pdf file. DO NOT submit documents into the body of an email. DO NOT submit documents as images. Scan them. There are apps available to download on your phone to scan documents. Please put your program name in the Subject line of EVERY email, even if it is a simple question. Do not submit one document at the time. Scan all documents into one pdf attachment.
- One year from the date of your physical, a **physical waiver** must be submitted annually if there has been no change in your health status.
- **Initial PPD 2 Step is 4 office visits**: **1st** – administered **2nd** – read 48-72 hrs. after 1st visit, **3rd** – administered again 7-21 days later, **4th** – read 48-72 hrs. after 3rd visit.
- We recommend for Step 2 to be administered 7 days after Step 1; however, the max time frame between Step 1 and Step 2 is 21 days.
- You must have an **annual PPD or QFT**. Do not let time lapse or you will need to complete the PPD 2 step again. Example: If your PPD 2 Step was completed May 1st, your annual PPD 1 Step MUST be completed no later than May 1st.
- **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 every semester.
- **Hepatitis B** - There are 3 options to choose from:
  1- 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 2 boxes of the Hep B Waiver (page 16), sign, date and remit along with Dose # 1. *If you received 3 doses in the past, we will accept those as your 3 doses.
  2- You may have a 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 one.
  3- If you opt out, please see the Hepatitis Declination Waiver on page 16. Check the first box, sign & date.

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**
- Requires successful completion of cognitive and skills demonstration for healthcare provider (Adult, Child, Infant, and Choking Skills)
- Must renew CPR certification every 2 years

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. The student is responsible for remitting a copy of the BLS Card to the Clinical Admissions Specialist. Cards typically take 30 days to receive. 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 available

Prices and Information Subject to Change

Class Must Be:
"CPR/BLS (Basic Life Support) for Healthcare Provider" from the
American Heart Association or the American Red Cross ONLY

Horry-Georgetown Technical College - Continuing Education – Betty Turner, Program Manager Cost: $105.00 (Materials Included) 743 Hemlock Avenue, Bldg. 600 Room 627, Myrtle Beach, SC 29577 - 843-477-2020 or 843-477-2079 Betty.Turner@hgtc.edu Dates of CPR classes can be found at www.hgtc.edu/jobtraining under Allied Health.	**Horry County Fire & Rescue** Training Center ID: SC20285 2560 Main St Suite 1 Conway, SC 29526-3756 843-915-7289 https://www.horrycountyfirerescue.com
Heart To Heart-CPR, LLC – Randy and Kim Armstrong Cost: $45.00 (Materials Included) 843-999-8451 or 854-999-6609 Randal.Armstrong@att.net or KimArmstrong57@att.net	**Andy Brown** Cost: $65 843-957-0124 ambrownl2345@gmail.com
Midway Fire Department Training Center ID: SC05971 112 Beaumont Dr Pawleys Island, SC 29585-7589 843-545-3620 cgilmore@gtcounty.org http://www.midwayfirerescue.org	**McLeod Regional Medical Center** Training Center ID: SC15248 555 E Cheves St Florence, SC 29506 843-667-2000
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** Training Center ID: NC05367 US301 N & I-95 Lumberton, NC 28359 910-272-3408 fgwillia@robeson.cc.nc.us
Pee Dee Regional EMS Training Center ID: SC15505 1314 W Darlington St Florence, SC 29501-2122 8436625771 www.pdrems.com http://www.pdrems.com	**Southeastern Regional Medical Center** Training Center ID: NC06011 PO Box 1408 Lumberton, NC 28359 910-671-5805

NOTE: Students 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 an approved vendor to schedule your Part 2 Skills Assessment. 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 following class, you will also need to remit a copy of your BLS Card to hgtc-clinical@hgtc.edu.

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

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? CHECK Yes or NO	Yes	No	**Have you had? CHECK Yes or NO**	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):		

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

If you checked "Yes" to any past 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/ _____
LEFT: 20/ _____

Hearing: (Please circle)
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 **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

ESSENTIAL FUNCTIONS REQUIRED OF STUDENTS FOR ADMISSION AND PROGRESSION IN THE

_____
(PROGRAM NAME)

The following standards are considered essential criteria for participation in the Allied Health Programs. Students selected for Allied Health 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 Allied Health Programs. In order to be admitted, or to be retained in the Allied Health Programs after admission, all applicants with or without accommodations must (by initialing the items you agree the student will be able to perform the function):

- **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**

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)					☐ Negative ☐ Positive	_____**mm**		
Step 2 (2 visits)					☐ 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: _____

HEPATITIS B FORM

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

Or

Hepatitis B Titer Result: _____ Date: _____ Initials: _____

Or

Declination/Waiver (Must sign page 4 of HGTC Health Science Division - Student Health Record)

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/DECLINATION

Check the appropriate box(es) to indicate your compliance with the Hepatitis B requirement.
If you have not completed the entire series, please check the **first two boxes**.

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, a serious disease. 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 make arrangements at that time.

SERIES IN PROGRESS

❑ * I am in the process of receiving the Hepatitis B Vaccine and will provide documentation of all three vaccinations as they are completed.

SERIES COMPLETED

❑ I have completed the series of three vaccinations (submit via immunization record or form 7)

_____

Student Signature H# Date

PROFESSIONAL LIABILITY INSURANCE

Required for the following Allied Health Programs:

Dental Assisting (DAT)

Dental Hygiene (DHG)

Diagnostic Medical Sonography (DMS)

EMT/Paramedic (EMS)

Licensed Practical Nurse (LPN/PNR)

Nursing Assistant (AHS 163)

Phlebotomy (AHS 167)

Physical Therapy (PTH)

Radiology Tech (RAD)

Registered Nurse (NUR)

Respiratory Care (RES)

Surgical Tech (SUR)

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

Visit www.hpso.com ** – 1-800-982-9491

Select "Get a Quote – Apply Now"

Select "Individual" and "Continue"

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 06/30/2021, the Annual Premium was $42.10. 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. **IF THESE PROVIDERS DON'T WORK FOR YOU, YOU MAY USE YOUR OWN PROVIDER.**

Immunization	Beach Family & Urgent Care 843-626-2273	Carolina Health Pharmacy 843-215-8200	CVS Minute Clinic 866-389-2727	Doctor's Care 843-238-1461	Little River Medical Center (5 different locations) 843-663-8000	Med Plus 843-357-2443	Palmetto Express Clinic 843-750-0324	Southern Urgent Care 843-357-4357
Tuberculin Skin Testing (PPD) x 1 OR *QFT Gold Blood Assay	$25.00 (PPD) $132.00 (QFT)	NA	$74.00	$34.00 $60.00 (QFT)	Sliding Scale	$25.00	$20.00 (PPD) $100 (QFT)	$35.00 (PPD) $110.00 (QFT)
Chest X-Ray with Positive PPD	$53.00	NA	NA	$100.00	Sliding Scale	$50.00	NA	$100.00
MMR Titer	$90.00	NA	$99 - $139	$80 each +$51 stick fee	Sliding Scale	NA	$60.00	$50.00
Varicella Titer	$40.00	NA	$99 - $139	$85.00	Sliding Scale	NA	$30.00	$50.00
Hep B Titer	$32.00	NA	$99 - $139	$75.00	Sliding Scale	NA	$30.00	$30.00
MMR Vaccine x 1	NA	$115.00	$135.00	NA	Sliding Scale	$90.00	NA	NA
Hep B Vaccine x 1	NA	$92.00	$145.00	$156.00	Sliding Scale	$90.00	NA	NA
Varicella Vaccine x1	NA	$168.00	$140.00	NA	Sliding Scale	$125.00	NA	NA
TDAP (Adacel) Vaccine	NA	$64.00	$95.00	$71.00	Sliding Scale	$70.00	NA	$65.00
Flu	$28.00	$28.00	$50.00	$29.00	Sliding Scale	$25.00	$30.00	$35.00
Physical Exam	$75.00	NA	$89.00	$50.00	Sliding Scale	$100.00	$50.00	$45.00

For students who meet certain income guidelines, many of these 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
- Conway Health Dept., Industrial Park Road, Conway
- Stephen's Crossroad Health Dept., Hwy 57 North, Little River
- Georgetown County Public Health Department, Lafayette Cir, Georgetown

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 Every Semester)

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 ❑ **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 _____	

- Certain health conditions/diseases are considered valid contraindications to vaccine administration.
- Pregnancy <u>is not</u> a contraindication to receiving inactivated vaccines such as: Hepatitis B vaccine, TDAP vaccine, or Flu vaccine *(CDC Recommended Adult Immunization Schedule – United States 2010)*
- Breast-feedings is not a contraindication for any vaccine, except smallpox *(CDC, New ACIP Guidelines, May 2008)*

Certification:

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

_____

Signature Title (MD, NP, PA)

_____

Signature Title (MD, NP, PA)

_____