HORRY GEORGETOWN TECHNICAL COLLEGE

Health Tracker Clinical Requirements

for

Massage Therapy

Table of Contents

STUDENT NAME: _____ **PROGRAM:** **Massage Therapy**

		Clinical Requirements Checklist Any item that will expire during a semester must be completed before the semester begins.	Renewal Interval	Date Obtained	Expiring Date
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☐		**Physical Waiver** - *ONLY if there are no medical changes	1 Year		
☐	2.	**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
☐		**Annual Tuberculin Skin Test** 1 Step PPD **OR** QFT Gold Blood Assay 1 Step PPD (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	1 Year PPD-SA Date:		
☐	3.	**TDAP (ADULT) -** Immunization x 1	10 Years		
☐	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.	**MMR Titers – LAB Results w/Score & Reference Range Required** Measles (Rubeola): ☐- ☐+ If NEG or equivocal = MMR x2 Mumps: ☐- ☐+ If NEG or equivocal = MMR x2 Rubella (German Measles): ☐- ☐+ If NEG or equivocal = MMR x1	Initial		NA
		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		

IMPORTANT NOTES

- **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.
- **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.

- **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 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 or Measles, 2 boosters are required. Only 1 booster is needed for Rubella. For the 2 boosters, a prior vaccination (childhood, military, etc.) can count as the 1st one and you will only need to receive the one booster. You will need to remit a copy of your immunization record.

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.

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):		

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

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/ _____ 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 **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 complete 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: _____

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

_____

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
The actual titer lab results with scores and reference ranges must accompany this form

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.

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 ❑ **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.

_____

Signature Title (MD, NP, PA)

_____

Signature Title (MD, NP, PA)

_____