Tunxis Community College
A Connecticut Community College

Education That Works For a Lifetime

HEALTH FORM

This Health Form is required and due prior to lab/clinical experiences for the following programs.

Please check:

☐ Certified Nurse Aide
☐ Certified Phlebotomy Technician
☐ Registered Medical Assistant

STUDENTS: Fill in areas under Please Print and Emergency Contact.
PROVIDERS: Fill in Physical exam and initial.
Scan e-mail all health forms to Cheryl Conaty, RN, Allied Health Coordinator - cconaty@tunxis.edu

PLEASE PRINT

Name_____ Date of Birth_____ Banner ID# _____

Phone_____ Email _____

EMERGENCY CONTACT

Name _____ Relationship to student _____ Phone# _____

Date of Physical Exam _____

Does student have a Latex Allergy? (circle) YES NO

Is student clear to participate in lab/clinical portion of Healthcare programs without restrictions? (circle) YES NO
If no, explain the nature of restrictions/limitations.

_____

_____

_____

_____

Would these limitations affect the student's ability to provide safe care? Please explain.

_____

_____

_____

Provider initial _____

(OVER)

Name_____ Date of Birth _____ Banner ID# _____

If immunizations/vaccinations or blood titers are not obtained by this healthcare provider, please attach a document of proof. PROVIDERS: Please initial and circle in applicable areas for titers. Full dates required, not just the year.

If titers are provided, they must be positive or show dates of vaccination(s).

Measles, Mumps, Rubella #1_____ #2_____ or Titer Immune (circle) YES NO Provider Initials _____
Immunization Dates

Varicella (Chickenpox) #1 _____ #2_____ or Titer Immune (circle) YES NO Provider Initials _____
Immunization Dates

Td (TETANUS booster)_____ Provider Initials _____
Date within 10 years

Flu Vaccine – REQUIRED _____ Provider Initials _____
Date given (must be given within the last year)

Tuberculin Test/PPD _____ _____ _____ **OR QFT-G**_____ _____ Provider Initials _____
Date given Date read Results Date done Results

***Hepatitis B series**_____ _____ _____ Provider Initials _____
Date/#1 Date/#2 Date/#3

*Hepatitis B Surface Antibody Titer_____ Immune (circle) YES NO Provider Initials _____
Date

I waive the Hepatitis B vaccination at this time.

Student Signature: _____ Date: _____

Note: The student must sign this waiver if they have not received all 3 vaccinations in the series OR NO IMMUNITY.

HEALTHCARE PROVIDER INFORMATION

Name_____ Telephone_____
Please print

Signature_____ Date _____

Address _____
No. and Street City or Town State Zip Code