COMMUNITY COLLEGE
OF RHODE ISLAND

Healthcare Requirements for Health Science Students

To Be Completed by your Primary Healthcare Provider

Student Name: _____ **Date of Birth:** _____/_____/_____

Phone Number:_____ **CCRI Email:**_____ **Student ID:** _____

Program of Study: _____

Allied Health/Dental/Rehab Health: All documentation must be sent to **CCRI School Nurse** via mail/fax/email.
Nursing: All documentation must be uploaded into **CastleBranch *AND*** sent to **CCRI School Nurse** via mail/fax/email.
CCRI Health Services, Room 1240, Angela Marshall, RN, 400 East Ave. Warwick, RI 02886
Phone: 401-825-2103, Fax: 401-825-1077, Email: nurse@ccri.edu.

General Requirements:

1. Influenza Immunization:

It is a requirement that all students receive an influenza immunization*. Proof of receiving the influenza immunization is required.
(Influenza immunization must be given Aug-March for the influenza season).
Allied Health/Dental/Rehab Health students must comply by **November 1st**.
Nursing students must comply by **September 30th.**

**If you have a medical exemption, a Rhode Island Department of Health Medical Immunizations Exemption Certificate for Use in Healthcare Facilities must be included.*

Agency Name:_____ **Vaccination Date:** _____/_____/_____

2. CPR CERTIFICATION:

Must be American Heart Association BLS OR Military CPR training network card. RED CROSS CPR TRAINING IS NOT ACCEPTABLE.

These are the only accepted CPR credentials and must remain up to date throughout the program.

****Not required for Health Care Interpreter students.***

3. Color Blindness:

*(To be completed **ONLY** by students in the **Allied Health** programs; excludes Nursing, Rehab, Dental, X-ray, Respiratory, and CTIC.).)*

Pass Fail

4. Admission Physical Exam: *(To be completed no more than one year prior to admission to Health Science Programs)*

Start Date of Health Science Program: ___/_____/_____.

I hereby certify that (student name) _____*has had a physical exam on* ____/____/____ *and is in good health and able to participate in all clinical activities without limitations.*

Healthcare Provider (Please print):_____

Signature and Title: _____ Date: _____

***To ensure accuracy, students must put their name and ID on each of the pages. Doctors must also sign and date each of the pages.**

Approved in conjunction with the Rhode Island Department of Health. Revised: February 2018, July 2021, April 2022

Student Name: _____ **Student ID:** _____

Immunization Requirements:

In accordance with the Rhode Island Department of Health's Rules and Regulations Pertaining to Immunization, Testing and Health Screening for Health Care Workers (R23-17-HCW), Health Science Students must meet the following requirements:

1. One dose of Tetanus-Diphtheria-Pertussis (Tdap):

Date: _____/_____ /_____

2. Measles, Mumps, and Rubella vaccine (MMR):

Two doses administered **a minimum** of four weeks apart. First dose must be given on or after first birthday.

Dose # 1 Date: _____/_____/_____ Dose # 2: Date: _____/_____/_____

OR Titer Lab Sheet Results Showing Immunity _____/ _____/_____

3. Varicella (Chickenpox):

Varicella vaccine: Dose # 1: Date: _____/_____/_____Dose # 2: Date: _____/_____/_____

Two doses administered **a minimum** of 12 weeks apart if vaccinated before age 13; 4 weeks apart if vaccinated at age 13 or older.

OR Healthcare provider's documentation as to proof of date of Chicken Pox disease: Date: _____/_____/_____

OR Titer Lab Sheet Results Showing Immunity _____/ _____/_____

4. Meningococcal Vaccine:

*Please note: This is strongly recommended but not a requirement.

One (1) dose of meningococcal conjugate (MCV4) vaccine if under 22 years of age: **AND** evidence of second booster dose **if** the first MCV4 dose was given **before 16 years of age.**

Date: _____/_____/_____ ***AND*** (if indicated) Booster Date: _____/_____/_____

Meningitis B Vaccine: This is strongly recommended but not a requirement.

One (1) dose of vaccine if under 22 years of age, ***AND*** evidence of second booster dose **if** the first dose was given before 16 years of age.

Date: _____ /_____ /_____ ***AND*** (if indicated) Booster Date: _____ /_____ /_____

5. Covid-19 Vaccine:

1st dose: _____ /_____ /_____ 2nd dose: _____ /_____ /_____Booster #1: _____ /_____ /_____

Upload Covid-19 information by going to MYCCRI using login credentials, click For Students tab to verify vaccination.

Healthcare Provider (Please print):_____

Signature and Title: _____ Date: _____

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Student Name: _____ **Student ID:** _____

6. Hepatitis B vaccine: Please note: The Hepatitis B vaccination series consists of three (3) doses of vaccine given as two (2) doses four (4) weeks apart followed by a third dose five (5) months after the second dose.

Please select one of the following:

☐ **Option 1** - You have been vaccinated but have no record of the immunizations. A positive antibody titer is required. See section 7.**

☐ **Option 2** – You have received all or part of the vaccination series OR need to begin the vaccination series. Please document all vaccinations and/or titers that have been completed to date. Three (3) vaccinations are needed and a positive antibody titer is required one (1) to two (2) months after the final vaccination. **

Dose # 1 Date: ___/___/_____ Dose # 2: Date: ___/___/_____ Dose # 3: Date: ___/___/_____

Titer: Date: ___/___/_____

In the event that the indicated titer is negative for immunity, it is recommended that students consult their physician regarding the need for a booster or repeat Hepatitis B series.

☐ **Option 3** - You have received the childhood vaccination series. Submit record of all 3 vaccinations. (Titer not required.)

Dose # 1 Date: ___/___/_____ Dose # 2: Date: ___/___/_____ Dose # 3: Date: ___/___/_____

☐ **Option 4 - Hep B (Heplisav)** Dose #1 Date _____/_____/ ____ Dose #2 _____/ _____/ _____

***Students must attach lab results of Hepatitis B Surface Antibody titer. MUST include all range values.**

7. Titers: *(To be completed **ONLY** by students who have been vaccinated but have no documentation. Their Doctor may indicate immunity)*

MMR *IgG* titer: A positive IgG titer for each:

Measles: _____/_____/_____, Mumps: _____/_____/_____, Rubella: _____/_____/_____

Varicella *IgG* titer:

If you have history of disease but do not have evidence: A positive Varicella IgG titer Date: ___/_____/_____

Hepatitis B Surface Antibody titer:

If you have received vaccination but do not have evidence: A positive Hepatitis B Surface Antibody titer Date: _____/_____/_____

*Please note, titers may show negative or indeterminate results for immunity. In such cases, students will be required to be vaccinated.

Students must attach lab results of all titers. MUST include all range values.

NOTE: Titers are available through East Side Lab for a discounted rate. You must contact CCRI's Health Services nurse for a lab slip at 825-2103

Healthcare Provider (Please print):_____

Signature and Title: _____ Date: _____

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COMMUNITY COLLEGE OF RHODE ISLAND

Initial TB Assessment Form

To Be Completed by your Primary Healthcare Provider

Student Name: _____ **Date of Birth:** _____

Student ID: _____ **Campus:** _____ **CCRI Email:** _____

Allied Health/Dental/Rehab Health: All documentation must be sent to **CCRI School Nurse** via mail/fax/email.
Nursing: All documentation must be uploaded into **CastleBranch** and sent to **CCRI School Nurse** via mail/fax/email.

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Baseline Two-Step Tuberculin Skin Test *(TST): **New Admission into Nursing Program:** Must have two TSTs planted, at least one week apart – **OR** – one negative TST in the last year **AND** one negative TST during conditional acceptance period. **All other students** must have two TSTs planted, at least one week apart but no more than 12 months apart.

For health care workers who can present documentation of serial tuberculin testing with negative results in the prior two (2) years (or more), a single baseline negative tuberculin test result is sufficient evidence of no current TB infection.

Step #1

Date given:___/___/___

Date Read: ___/___/___

Result :_____mm **(Circle one):** Positive/Negative

Read by:_____

Step #2

Date given:___/___/___

Date Read: ___/___/___

Result :_____mm **(Circle one):** Positive/Negative

Read by:_____

OR

Interferon Gamma Release Assay (IGRA) Result: Date:_____

Positive Negative Indeterminate

Students must attach IGRA lab results.

If TST or IGRA are positive on baseline testing OR by history, then complete the following:

1. Chest X-Ray Date: _____/_____/_____Result: Normal Abnormal

2. Symptom Screen: (Check all that apply)

☐ No symptoms ☐ Cough ☐ Hemoptysis

☐ Unexplained weight loss ☐ Fever ☐ Night sweats

☐ If Chest X-Ray is normal and the student has no symptoms, student has Latent TB Infection (LTBI) and is cleared for school. Provider must treat and report LTBI to the Department of health on standard forms.
http://www.health.ri.gov/diseases.tuberculosis/for/providers/

☐ If Chest X-Ray is abnormal and/or student has symptoms of TB, please call the Department of Health at 401-222-2577

Student cleared to commence school: **Yes** **No**

Healthcare Provider (Please print):_____

Signature & Title:_____**Date:**_____

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Annual TB Assessment Form

To Be Completed by your Primary Healthcare Provider

Student Name: _____ **Date of Birth:** _____/_____/_____

Student ID: _____ **Campus:** _____ **CCRI Email:** _____

Allied Health/Dental/Rehab Health: All documentation must be sent to **CCRI School Nurse** via mail/fax/email.
Nursing: All documentation must be uploaded into **CastleBranch** and sent to **CCRI School Nurse** via mail/fax/email.

CCRI Health Services, Room 1240, Angela Marshall, RN, 400 East Ave. Warwick, RI 02886
Phone: 401-825-2103, Fax: 401-825-1077, Email: nurse@ccri.edu.

Yearly Screening Requirement:

1. Baseline TST/IGRA Negative Students must get a yearly TST or IGRA test in the same month as initial test.

2. Baseline TST/IGRA Positive LTBI or active TB cases who have completed therapy need no further follow up but must be counseled to report symptoms if any develop.

3. Baseline TST/IGRA Positive LTBI cases that are NOT treated require a yearly visit for assessment of freedom from active TB by symptom check. No X-Ray is needed if symptom free. Encourage student to get treated for LTBI.

4. Report all annual screening results to CCRI in writing.

*Note: In the instance of a Positive TST or IGRA, Initial X-Ray is good for up to 5 years. This form (Annual TB Assessment Form) must be submitted annually.

Annual Tuberculin Skin Test (TST):

*Negative students must get a yearly TST or IGRA test in the same month as initial test.

Doctor must provide interpretation (Positive/Negative) and record as mm of induration.

Annual TST Date: _____/_____/_____ **Test Result (Circle one):** Positive/Negative, **Reading Value:** _____mm

OR

Interferon Gamma Release Assay (IGRA) Result:

Positive Negative Indeterminate

Annual Symptom Check: Date: __/_____/_____

Symptom Screen: (Check all that apply):

☐ No symptoms ☐ Cough ☐ Hemoptysis

☐ Unexplained weight loss ☐ Fever ☐ Night sweats

Student is cleared to commence school: Yes No

Healthcare Provider (Please print):_____

Signature and Title: _____ Date: _____

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