Collin College
2200 W. University Dr.
McKinney, TX 75071

Polysomnographic Technology Program
Pre-Entrance Medical Statement

Introductory Statements:

Immunization of Health-Care Workers: Recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC)

ACIP strongly recommends that all Health Care Workers (HCWs) be vaccinated against (or have documented immunity to) hepatitis B, influenza, measles, mumps, rubella, and varicella.

Tetanus, Diphtheria, and Pertussis: After primary vaccination, a tetanus-diphtheria-pertussis (TDAP) booster is recommended for all persons every 10 years. HCWs should be encouraged to receive recommended TDAP booster doses.

Influenza vaccine is strongly recommended in the fall of the year.

Pneumococcal Vaccine is recommended for "at risk" individuals such as those over age 65, or those with a condition that may increase the risk for the disease, such as those with HIV and other immune compromise, as well as those with cardiovascular and other diseases.

Tuberculosis screening by PPD skin test or blood test within 6 months of start, then yearly.

Student Health Care providers are required to have two doses of the MMR (measles, mumps, rubella) vaccination. Student health care providers born on or after January 1, 1957 must show proof of immunity to measles or two doses of the MMR vaccination.

Texas law requires that all students under the age of 22 entering college or university after January 1, 2012, must be vaccinated for bacterial meningitis.

Other vaccines may be required based on personal risk factors. Please consult the Texas Department of Health and CDC for recommendations.

https://www.cdc.gov/vaccines/hcp/acip-recs/index.html

https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html

Additional Source: Texas Administrative Code, Title 25, Part I, Chapter 97, Subchapter B, Rules 97.62, 97.64, 97.65

Polysomnographic Technology Program
Pre-Entrance Medical Statement

Instructions: This form should be completed before the start of the program. Part I is to be completed by student. Part II to be completed under the direction of a Physician or Nurse Practitioner.

Part I - Health Questionnaire: To be completed by student:

Social Security Number: _____ Date:_____

Name:_____ Birth date:_____
Last First Middle

Address:_____
Street City/State Zip

Telephone:_____ _____
Home Work

Do you have any physical limitations which would affect your ability to lift, turn, and transfer patients?

Yes_____

No_____

Do you have any limitation in the use of your senses, such as sight or hearing that would limit your ability to practice a health profession?

Yes_____

No_____

Do you have any other condition which might interfere with you ability to practice a health profession?

Yes_____

No_____

Have you used any medications on a regular or frequent basis during the past year?

Yes_____

No_____

If you answered "Yes" to any of the above questions, please explain your limitations in detail on a separate sheet of paper.

I, _____, certify that the information provided on this sheet
Print Name

is true to the best of my knowledge. _____ _____
Signature Date

Part II - Health Screening: To be completed by, or under the direction of a physician. Please note all immunizations are **required** unless noted.

A. Medical documentation of the following must be submitted to the program:

- **Tuberculosis (TB) Screening:** Test 1 must be completed by the fall of the first year of the program, and Test 2 must be completed one year later. If the screening result is positive, the student must provide a chest x-ray showing clear lungs.
- **Hepatitis B:** 3 vaccinations required or a titer showing immunity. This series takes 6-7 months to complete, so the first dose must be completed by the May application deadline.
- **Measles, Mumps, Rubella (MMR):** 2 vaccinations required or a titer showing immunity.
- **Tetanus/Diphtheria/Pertussis (TDAP):** Record showing vaccination within the last 10 years.
- **Varicella (Chicken Pox):** 2 vaccinations required or a titer showing immunity. A note from the physician showing the student had chicken pox previously is not sufficient.
- **Influenza:** Must be taken annually in the fall.
- **Bacterial Meningitis:** Only required if the student is under the age of 22 years.
- **Hepatitis A (Strongly Recommended):** 2 vaccinations.
- **Pneumococcal (Optional):** If required due to a personal risk factor.
- **Other:** Specific immunization(s) due to personal risk factor.

Initial to indicate medical documentation has been submitted to the program:

	TB Screening #1
	TB Chest X-Ray (if applicable)
	Hepatitis B Dose 1
	Hepatitis B Dose 2
	Hepatitis B Dose 3
	Hepatitis B Titer Showing Immunity
	MMR Dose 1
	MMR Dose 2
	MMR Titer Showing Immunity
	TDAP
	Varicella Dose 1
	Varicella Dose 2
	Varicella Titer Showing Immunity
	Influenza Year 1
	Bacterial Meningitis (if applicable)
	Hepatitis A Dose 1 (strongly recommended)
	Hepatitis A Dose 2 (strongly recommended)

List any additional immunization records submitted to the program:

Note: TB Screening #2 and the Influenza vaccination for Year 2 will be required by the fall of the second year of the program.

B. Physical Exam: To be completed by or under the direction of a physician.

Height:_____ Weight:_____ Temp:_____ BP:_____

Glasses or Contact Lenses used: Yes_____ No_____

History: Please include any significant information regarding previous or current medical condition/s that may affect the individual's ability to safely care for patients in a clinical setting. Include medical and or surgical conditions, and or abuse of alcohol or drugs. Please attach a separate sheet of paper if required and note "see attached explanation here."

_____

_____

_____

Recommendation:

Based on your physical examination, is the applicant able to turn and or move heavy objects? If no, please describe.

Yes_____

No_____

Regarding the ability to practice a health care profession, is the applicant able to see and hear adequately? If no, please explain.

Yes_____

No_____

Is the applicant free of any pathological conditions, either physical or mental which would interfere with the practice of a health care profession? If no, please explain.

Yes_____

No_____

_____ _____

Name of Physician or Nurse Practitioner Address

_____ _____

Signature of Physician or Nurse Practitioner Date of Exam

Release Authorization: To be signed by the student.

I authorize the release of any part of this pre-entrance medical statement to any clinical affiliate upon request.

_____ _____

Student Signature **Date**