Phlebotomy Health Packet

Student Health Record:

- Sign the records release
- A Tb skin test **(**PPD) **or** a QF-TB blood test
- The physical exam must be completed by an MD, DO, PA, or NP

Required Immunizations (ATTACH all documentation):

- **MMR (Measles, Mumps, Rubella):** 2 doses **or** copy of lab titer (all three components)
- **Varicella:** 2 doses **or** copy of lab titer (we cannot accept "History of Disease")
- **Hep B:** full series OR you may request a declination form (Note: It is highly recommended you get vaccinated. Phlebotomy is a high-risk occupation for needlestick injury.)
- **COVID vaccination** OR you may request a declination form
- **Influenza (Flu):** To be determined based on location and timing of clinical assignment.

Additional Requirements:

- Proof of insurance (picture of your insurance card) or you may request a waiver

Note: Some clinical sites require a criminal background check. This will be done on a case-by-case basis.

Forms can be **emailed** (preferred), mailed, hand-delivered, or faxed. Please reach out with any questions.

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STUDENT HEALTH RECORD

The New York State Department of Health and Education requires a student to submit immunizations, a current (within one year) physical exam and tuberculosis status prior to participation in a health care program. This information is confidential and will be maintained in a medical file in the Health Compliance Office at OCC.

Program of Study: _____

Name:_____ DOB: _____

Address: _____

Phone:_____ Email:_____

Permission to Release Health Record Information:
I understand the Health Record will be treated as confidential and privileged. I hereby give my permission to the Clinical Compliance Office at Onondaga Community College to release my health form to contracted agencies as necessary for clinical rotations.

Student SIGNATURE: Date: _____

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TUBERCULOSIS QUESTIONNAIRE (completed by student)

- Have you ever had a positive TB skin test (PPD)? YES NO
- Have you received medication for the positive test? YES NO
- Did you receive BCG in another country? YES NO
- Have you been exposed to anyone with TB without wearing a N95 mask? YES NO
- Do you have frequent contact with anyone incarcerated or works in a prison? YES NO
- Have you spent more than 30 days in another country this year? YES NO
- Are you experiencing any of the following symptoms?

  Persistent fever YES NO

  Night Sweating YES NO

  Unexplained weight loss YES NO

  Weakness/Fatigue YES NO

  Persistent, productive cough YES NO

  Coughing up blood YES NO

  Chest pain YES NO
- Are you currently taking medication that suppresses your immune system? YES NO

Student SIGNATURE: _____ DATE:_____

REQUIRED TUBERCULOSIS TESTING (completed by health provider):

Tb Mantoux Skin Test (PPD) (ppd should be read within 48-72 hours after it was administered)

1) **PPD**: Date administered: _____ Date read: _____ Results: _____

   Health provider signature:_____

OR

QF-Tb: (*attach laboratory paperwork***)**

QF-Tb: Date drawn: _____ Results: _____

Phlebotomy Health Packet

HEALTH HISTORY AND PHYSICAL EXAM

Name: DOB:

Medical/Surgical History:

Allergies:

Medication:

T: BP: P: RR: Height: Weight:

Vision: corrected/uncorrected (circle) Right eye: Left eye:

Hearing Right ear: Left ear:

SYSTEMS REVIEW:

	Are there any abnormal findings?	Please list abnormalities
Head/Neck/Face	YES/NO	_____
Chest (Heart/Lungs)	YES/NO	_____
Abdomen	YES/NO	_____
Spine	YES/NO	_____
Skin	YES/NO	_____
Neurological	YES/NO	_____
Extremities	YES/NO	_____

I have performed the above medical evaluation and found to the best of my knowledge that this individual is free from physical or mental impairments and should be able to perform as a student within the School of Health and participate in various clinical experiences. This includes dependence on behavior altering substances which might interfere with the performance of duties or world impose a potential risk to patients or personnel. If this individual needs reasonable accommodations in order to achieve their responsibilities in the class and or workplace, please describe below:

MD Signature (required):_____ Date:_____

MD printed name, address, and phone number or stamp (required):