

###  SY01566_

**Lillian Duer James School of Nursing**

**P.O. Box 1189 Hamlet, NC 28345**

###  (910) 410-1884 • Fax (910) 582-7213

# Full Name *(print)*: Date Submitted:

**Name Preference:**

## Student Medical Form for

**(Check One)**

## □ Associate Degree Nursing (ADN)

## □ Practical Nursing (PN)

□ PN to ADN Transition (Advanced Standing)

## □ Nursing Assistant (NA)

## □ Emergency Medical Services (EMS)

## □ Phlebotomy

**DO NOT SEPARATE THESE FORMS**

**It is very important that you read and follow all directions in this packet.**

 **Ensure all information is completed before turning in packet.**

**Partially completed packets *will* *not* be accepted.**

**Thank you.**

**Copies of records may be attached, but information MUST be filled out, and signature is required by healthcare provider on forms.**

**MAKE A COPY OF THESE FORMS FOR YOUR RECORDS. FORMS ARE DESTROYED ONCE A STUDENT GRADUATES OR LEAVES THE NURSING PROGRAM.**

**RCC NURSING DEPARTMENT**

Student Immunization Requirements

1. **TUBERCULOSIS** *(TUBERCULIN SKIN TEST = TST)***:**
* Screening with a TST **within 12 months of starting program** (Note: Current and **annual** TB test required). Documentation of results must be in mm of induration.

**OR**

* TB Blood Test (i.e. IGRA) **within 12 months of starting program** (must provide lab report)

**OR**

* Documentation by medical provider of a chest x-ray is required for a past + PPD or blood test. If current +PPD or blood test, additional evaluation for TB disease will be required as deemed necessary from a healthcare provider

Students must report any community or clinical exposure to TB immediately to the school, and complete annual TB education and a TB Risk Assessment and Symptom Screen.

1. **MEASLES, MUMPS, AND RUBELLA** *(MMR)*:

Documentation from a healthcare provider of two (2) MMR vaccines (vaccine must include measles, mumps, and rubella components)

 **OR**

Documentation\* of a positive MMR titer (titer must include all components including measles, mumps, and rubella)

\**must provide lab report that indicates reference range*

1. **VARICELLA IMMUNITY:**

Documentation from a healthcare provider of two (2) Varicella vaccines

 **OR**

Documentation\* of a positive Varicella titer

\**must provide lab report that indicates reference range*

1. **TETANUS/DIPHTHERIA** *(Tdap)*:

Previously did not receive Tdap at or after age 11 years: 1 dose Tdap, then Td or Tdap every 10 years.

1. **INFLUENZA:**

Required annually - Fall See Academic/Agency guidelines (Due date to be announced annually, and not required prior to admission into the nursing program.)

“Optimally, vaccination should occur before onset of influenza activity in the community. Health care providers should offer vaccination by the end of October” on the Influenza Vaccination Information for Health Care Workers’ page. <https://www.cdc.gov/flu/professionals/healthcareworkers.htm>

1. **HEPATITIS B SERIES** *(HBV)***:**

Energix-B **or** Recombivax-B three (3) doses required (0, 1, and 6 months)

 **OR**

Heplisav-B two (2) doses required (4 weeks apart)

 **OR**

Documentation\* of a positive Hepatitis B titer

\**must provide lab report that indicates reference range*

 **OR**

Declination or waiver signed

Note: Declination or waiver must be on file at the school and/or be approved by the clinical facility or agency. Declination of vaccine is subject to approval from clinical agency.

1. **COVID-19 Vaccination**:

Documentation from a healthcare provider of COVID-19 vaccine series

 **OR**

Exemption status from each clinical site (Please note that you **MUST** get exemption from each clinical site to be have exemption status)

**Health and immunization requirements are based upon contractual agreements between the Richmond Community College Nursing Department and clinical agencies that provide clinical learning environments for students. Students must be in compliance with all health/immunization requirements to be eligible to participate in clinical opportunities at each facilities discretion. If a student does not meet and maintain health/immunization requirements for a specific agency, they are not eligible to participate in clinical in that facility. If the Nursing Department Chair determines that a student cannot satisfactorily meet clinical requirements of the nursing program, the student will not be allowed to progress in the nursing program, and will be dismissed from the program.**

**TO BE COMPLETED BY STUDENT (Print in ink)**.

Last Name (print) First Name Middle/Maiden Name \*Social Security Number

 ( )

Permanent Mailing Address City State Zip (Area Code) & Phone Number

Date of Birth (mo/day/yr) Gender □ M □ F □ Other Marital Status □ S □ M □ Other

**Insurance Information:**

 ( )

Hospital/Health Insurance (Name and Address of Company) (Area Code) Telephone Number

Name of Policy Holder Social Security Number Employer

 Is this an HMO/PPO/Managed Care Plan? □ Yes □ No

Policy or Certificate Number Group Number

**Emergency Contact Information:**

Name of Person to Contact in Case of Emergency Relationship

 ( )

Address City State Zip (Area Code) Telephone Number

\* Provision of Social Security number is voluntary, and is requested solely for administrative convenience and record-keeping accuracy. It is requested only to provide a personal identifier for the internal records of this institution.

***FAMILY & PERSONAL HEALTH HISTORY*** *(Print in ink) To be completed by student*

The health history is confidential, does not affect your admission status, and except in an emergency situation or by court order, will not be released without your written permission. *Attach additional sheets for any items that require more explanation.*

 Has any person, related by blood, had any of the following?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Relationship |
| High blood pressure |  |  |  |
| Stroke |  |  |  |
| Heart attack before age 55 |  |  |  |
| Blood or clotting disorder |  |  |  |
| High Cholesterol |  |  |  |
| Diabetes |  |  |  |
| Glaucoma |  |  |  |
| Cancer (type): |  |  |  |
| Alcohol/drug problems |  |  |  |
| Psychiatric illness |  |  |  |
| Suicide |  |  |  |

Have you ever had, or do you now have? *(Check at the right of each item that applies)*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| √ |  | √ |  | √ |  | √ |  |
|  | High blood pressure |  | Hay fever |  | Jaundice or hepatitis |  | Protein/blood in urine |
|  | Rheumatic fever |  | Allergy treatments |  | Rectal disease |  | Hearing loss |
|  | Heart disease |  | Arthritis |  | Severe/recurrent abdominal pain |  | Menstrual problems |
|  | Pain/pressure in chest |  | Concussion |  | Hernia |  | Irregular menstruation |
|  | Shortness of breath |  | Frequent/severe headache |  | Easily fatigued |  | Sinusitis |
|  | Asthma |  | Dizziness/fainting |  | Anemia, Sickle Cell |  | Blood transfusion |
|  | Pneumonia |  | Severe head injury |  | Eye problems (excluding needs glasses/contacts) |  | Sexually transmitted infections |
|  | Chronic cough |  | Paralysis |  | Bone, joint, or other deformity |  | Alcohol use |
|  | Head/neck radiation treatments |  | Disabling depression |  | Knee problems |  | Illicit drug use |
|  | Cancer (specify type) |  | Excessive worry/anxiety |  | Chronic back pain |  | Tobacco use |
|  | Diabetes |  | Ulcer (duodenal or stomach) |  | Neck or back injury |  | Anorexia/Bulimia |
|  | Serious skin disease |  | Intestinal disorder |  | Broken bone (specify) |  | Regularly exercise |
|  | Mononucleosis |  | Pilonidal cyst |  | Urinary tract infection |  | Wear seat belt |
|  | Frequent vomiting |  | Gall bladder disease/gall stones |  | Urinary stones (renal calculi) |  | Other (specify) |

List medications *(prescription or nonprescription)*. *(Include the frequency, and the dosage in which you use them)*

Name Frequency Dosage

Name Frequency Dosage

Name Frequency Dosage

Name Frequency Dosage

Name Frequency Dosage

Name Frequency Dosage

Name Frequency Dosage

Name Frequency Dosage

List allergies (include medications, food, latex, environmental, other) *Explain the type of reaction.*

|  |  |
| --- | --- |
| Allergy | Type of reaction |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Check each item “Yes” or “No.” Every item checked “Yes” must be fully explained in the space on the right (or on an attached sheet).

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Explanation |
| Do you have any condition or disability that limits your physical activities? (If yes, please describe) |  |  |  |
| Have you ever been a patient in any type of hospital? (Specify when, where, and why) |  |  |  |
| Has your academic career been interrupted due to physical or emotional problems? (Please explain) |  |  |  |
| Other than for a routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe) |  |  |  |
| Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details) |  |  |  |

**Student Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMMUNIZATION RECORD**

**(Print using black or blue ink). To be completed and signed by a medical provider or clinic. A complete immunization record from a physician or clinic may be attached to this form.**

Last Name First Name Middle Name Date of Birth

|  |  |
| --- | --- |
| **Immunization/Screening Requirement** | **Documentation of Compliance** |
| **TUBERCULOSIS** * Screening with a TST **within 12 months of starting program** Documentation of results must be in mm of induration

**OR** * TB Blood Test (i.e. IGRA) **within 12 months of starting program** (must provide lab report)

**OR*** Documentation by medical provider of a chest x-ray is required for a past + PPD or blood test. If current + PPD or blood test, additional evaluation for TB disease will be required as deemed necessary from a healthcare provider

Students must report any community or clinical exposure to TB immediately to the school, and complete annual TB education and an annual TB Risk Assessment and Symptom Screen | TST: Date read \_\_\_\_\_\_\_\_\_\_\_\_\_ Result \_\_\_\_\_mm of induration**OR**TB Blood Test Blood Test Date **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** *(Must attach lab report)***OR**□ Documentation by medical provider of chest x-ray attached for past + PPD or blood test□ Documentation by medical provider of additional evaluation for TB disease as deemed necessary from a healthcare provider if current + PPD or blood test |
| **MEASLES, MUMPS, AND RUBELLA** (*MMR)* Two MMR vaccines **OR**Positive MMR titer (must include all components including measles, mumps, and rubella)\**Provide lab report that indicates reference range* | MMR vaccine #1 *(date)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MMR vaccine #2 *(date)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**OR**□ MMR titer lab report attached |
| **VARICELLA**Two Varicella vaccines **OR**Positive Varicella titer\**Provide lab report that indicates reference range* | Varicella vaccine #1 *(date)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Varicella vaccine #2 *(date)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**OR**□ Varicella titer lab report attached |
| **TETANUS/DIPHTHERIA** *(Tdap)*One Adult Tdap (at or after age 11 years)**And**Tdap or a TD booster within 10-years | Tdap vaccine *(date)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**And**Tdap or Td booster vaccine if greater than 10 years *(date)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **INFLUENZA**Required annually – in the Fall See Academic/Agency guidelines (Due date to be announced annually, and not required prior to admission into the nursing program.) | □ current/upcoming year vaccine not available at this time□ Declined due to allergy *(written statement from medical provider required)* |
| **HEPATITIS B SERIES** *(HBV)*Energix-B **or** Recombivax-B three (3) doses required (0, 1, and 6 months) **OR**Heplisav-B two (2) doses required (4 weeks apart) **OR**Documentation\* of a positive Hepatitis B titer\**must provide lab report that indicates reference range***OR**Note: Declination or waiver must be on file at the school and/or be approved by the clinical facility or agency to attend clinical in that facility.  | Energix-B or Recombivax-B *(3 doses required)*Date of 1st dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of 2nd dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of 3rd dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**OR**Heplisav-B *(2 doses required)*Date of 1st dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of 2nd dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**OR**□ Hepatitis B titer lab report attached**OR**□ Declined *(student must sign RCC declination/waiver)*Note: declination of vaccine is subject to approval from clinical agency.  |
| **COVID-19**Pfizer or Moderna or Novavax (2 doses)Johnson and Johnson (1 dose)Booster for any of the vaccines (optional) | COVID-19 vaccine #1 *(date)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_COVID-19 vaccine #2 *(date)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OROne Dose (J&J) (date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Booster (if received)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Signature or Clinic Stamp REQUIRED:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of **healthcare provider** Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Print name of **healthcare provider** Area Code/Phone Number

Office Address

City State Zip Code

**PHYSICAL EXAMINIATION**

(Print) – To be completed and signed by healthcare provider

Last Name First Name Middle Name Date of Birth (mo/day/year)

Height \_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_ TPR \_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_ BP \_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **VISION**Corrected Right 20/ \_\_\_\_\_\_\_\_ Left 20/ \_\_\_\_\_\_\_\_\_\_Uncorrected Right 20/ \_\_\_\_\_\_\_\_ Left 20/ \_\_\_\_\_\_\_\_\_\_Color Vision \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **HEARING**(gross) Right \_\_\_\_\_\_\_\_\_\_\_ Left \_\_\_\_\_\_\_\_\_\_\_\_15 ft. Right \_\_\_\_\_\_\_\_\_\_\_ Left \_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |
| --- | --- | --- | --- |
| Are there abnormalities? | Normal | Abnormal | DESCRIPTION (attach additional sheets if necessary) |
|  1. Head, Ears, Nose, Throat |  |  |  |
|  2. Eyes |  |  |  |
|  3. Respiratory |  |  |  |
|  4. Cardiovascular |  |  |  |
|  5. Gastrointestinal |  |  |  |
|  6. Genitourinary/Breast |  |  |  |
|  7. Musculoskeletal |  |  |  |
|  8. Metabolic/Endocrine |  |  |  |
|  9. Neuropsychiatric |  |  |  |
| 10. Skin |  |  |  |

A. Is student under treatment for any medical or emotional condition? □ Yes □ No

 Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

B. Recommendation for physical activity (physical education, intramurals, etc.) □ Unlimited □ Limited

 Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Based on assessment of physical and emotional health, this individual appears to be able to participate in the activities of a health profession in a clinical setting, and provide safe care to the public.** □ **YES** □ **NO** **if no, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Signature or Clinic Stamp REQUIRED:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of healthcare provider Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Print name of healthcare provider Area Code/Phone Number

Office Address

City State Zip Code

The physical examination for Richmond Community College Nursing Programs includes an assessment of the applicant’s physical and emotional health prior to participation in a clinical setting. These criteria should be

included in the assessment:

|  |  |  |
| --- | --- | --- |
| **Meets Criteria** | **Does Not Meet Criteria** |  |
|  |  | **Communications Skills:** Students shall possess communication abilities sufficient for verbal and nonverbal interaction with others. Example: Students shall be able to explain treatment procedures and provide patient teaching to clients and families, document client response, and report to others the client’s response to nursing care. |
|  |  | **Mobility:** Students shall possess physical abilities sufficient to move from room to room and maneuver in small spaces and stand and walk for extensive periods of time. Example: Students will be able to move around in client’s room, move from room to room, move in small work areas, and administer CPR. |
|  |  | **Motor Skills:** Students shall possess gross and fine motor skills sufficient to provide safe and effective nursing care. Example: Students shall be able to calibrate equipment, position clients, administer intravenous, intramuscular, subcutaneous, and oral medications, insert catheters, and apply pressure to stop bleeding. |
|  |  | **Hearing Skills:** Students shall possess auditory ability sufficient to monitor health needs and collect data. Example: Students shall be able to hear alarms, listen to heart and breath sounds, and hear a cry for help. |
|  |  | **Visual Skills:** Students shall possess visual ability sufficient for observation and data collection. Example: Students shall be able to observe color of skin and read the scale on a syringe. |
|  |  | **Tactile Skills:** Students shall possess tactile ability sufficient for data collection. Example: Students shall be able to detect pulsation and feel skin temperature. |
|  |  | **Weight-bearing:** Students shall possess the ability to lift and manipulate/ move 40-50 pounds. Example: Students shall be able to move equipment and position clients. |

Explanation of criteria **NOT** met and projected time frame, if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Signature of Physician/Physician Assistant/Nurse Practitioner Date**

**Richmond Community College**

**Nursing Department**

***HEPATITIS B VACCINE DECLINATION (WAIVER)***

**Student Name (print):**

I am declining the Hepatitis B vaccination at this time.

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at high risk of acquiring Hepatitis B Virus (HBV) infection.

I have read the Hepatitis B Vaccine Information Statement (VIS) <https://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-b.pdf>. I understand the protection the vaccine could offer and have been given the opportunity to be vaccinated at my expense. However, I am declining Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

If in the future I want to be vaccinated with Hepatitis B vaccine, I will arrange to obtain the vaccine from my health care provider and notify the Nursing Department Chair and supply promptly the appropriate documentation to include in my health record.

For the following reason, I decline vaccination at this time:

□ Personal reasons.

□ I have previously received the complete series of three Hepatitis B vaccination.

□ Antibody testing has revealed that I am immune to Hepatitis B.

□ Medical reasons, the Hepatitis B vaccine is contraindicated. *Attach medical documentation concerning the medical contraindication to the Hepatitis B vaccine.*

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**Student Signature Date**

*Place in Student File*