Name _____

Date: _____

☐ **Health Information Technology** ☐ **Medical Assisting**
☐ **Health Information Management** ☐ **Medical Scribe**

SC STUDENT ID# _____

Directions: Complete all the sections below and turn into the Health Sciences Division Office along with a copy of your official immunization documentation. ***Students who cannot complete or provide documentation of immunization requirements by the designated deadline will not be allowed to enroll in a Health Sciences program.***

Student is to record immunization information on this checklist. (This form is a reporting document for Shasta College Health Sciences -- Not intended to be an official record from healthcare provider). Official immunization documentation must be attached.

CPR Certification - must show documentation of current certification in:	
Basic Life Support (BLS) for the Healthcare Professional including Adult, Child & Infant Resuscitation and two-person rescue. Certification must have American Heart Association (AHA) emblem. ⓘ **CPR certification will be included in the Medical Assisting Program.**	Expiration Date: _____

Tetanus, Diphtheria, Pertussis (TDaP) - must show documentation of either:	
A. One-time dose of TDaP (includes pertussis) required for all Healthcare Personnel younger than age 65. **OR**	Date _____
B. Subsequent Td booster every 10 years following one-time TDaP (must include proof of previous TDaP)	Date _____

Varicella* **-** must show documentation of either:	
A. Two doses of Varicella vaccine administered at least 4-8 weeks apart **OR**	Date #1 _____ Date #2 _____
B. Proof of quantitative IgG titer showing positive/immune to Varicella **If titer shows as **negative OR equivocal immunity**, proceed to Option 1 or 2.	Date _____ Results _____
Options You must either: ***1)* provide proof of having previously received the original 2-dose vaccination series and having received one (1) booster after your negative titer **OR ***2)*** if you have no previous records, proof of obtaining the 2-dose series after your negative titer	***Option 1:*** Original Series given: Date #1 _____ Date #2 _____ Date of Booster: _____ ***Option 2:*** Series given: Date #1 _____ Date #2 _____

* Note: A previous diagnosis of chickenpox is **NOT** accepted as proof of Varicella immunity. Must submit documentation of either A or B as outlined above.

Measles, Mumps, Rubella (MMR) - must show documentation of either:	
A. **Two doses** of MMR vaccine administered at least 4-weeks apart **OR**	Date #1 _____ Date #2 _____
B. Proof of quantitative IgG titer showing positive/immune to Measles, Mumps, and Rubella **If titer shows as **negative OR equivocal immunity**, proceed to Option 1 or 2.	Measles: Date _____ Result _____ Mumps: Date _____ Result _____ Rubella: Date _____ Result _____
Options You must either: ***3)* provide proof of having previously received the original 2-dose vaccination series and having received one (1) booster after your negative titer **OR ***4)*** if you have no previous records, proof of obtaining the 2-dose series after your negative titer	***Option 1:*** Original Series given: Date #1 _____ Date #2 _____ Date of Booster: _____ ***Option 2:*** Series given: Date #1 _____ Date #2 _____

Hepatitis B - must show documentation of either:	
A. **Three doses** of vaccine. This series can be administered over a period of 4-6 months depending on your healthcare provider's preference; please start this series early. • **CDC standard recommendations are for series to be given at 0, 1, and 6 months.** • **CDC minimum requirements allow for series to be given at 0, 1, and 4 months.** **OR**	Date # 1 _____ Date # 2 _____ Date # 3 _____
B. Proof of Hepatitis B AB [antibody] Surface IgG titer (**NOT** AG [antigen]) showing positive/immune	Date _____ Results _____

Tuberculosis Screening - must show documentation of either:	
A. Two negative TB skin tests (PPD) results. 1st PPD must be completed within 12 months prior to program start date. 2nd PPD must be within 6 months prior to program start date. **OR**	Date # 1 _____ Result _____ **Date # 2 due with Part 2 Packet**
B. If PPD is positive or there is a history of positive PPD, there must be a record of a negative Quantiferon Gold TB test within the past year or chest X-ray within the past 2 years. A Confidential TB screening questionnaire must be completed by the student and healthcare provider. **OR**	Date _____ Results _____ **COMPLETE THE CONFIDENTIAL TB QUESTIONNAIRE FORM**
C. If applicant has previously had the BCG vaccination, they may be eligible to take the Quantiferon Gold TB Test. (Please contact the Health Sciences office for more information.)	Date _____ Results _____ **COMPLETE THE CONFIDENTIAL TB QUESTIONNAIRE FORM**

Influenza - must show documentation of:	
One dose of influenza vaccine annually during the recommended flu season (September through April). **DO NOT OBTAIN THE VACCINE OUTSIDE OF THE SPECIFIED FLU SEASON.** ***HIT/HIM students will submit this document with the Part 2 packet.**	Date _____

Student Statement: I hereby certify that all materials presented and all statements made are true and correct. I authorize investigation of all records submitted and am prepared to provide original documentation when requested. I understand that any misrepresentation of material facts may be cause for immediate disqualification and removal from the program.

Signature of Applicant: _____ Date: _____

For Health Sciences Division Use Only
Date Received:
Immunization official documentation verified by:
Notes: