Health Sciences & University Programs
HIT / HIM - Part 2 Pre-Enrollment Clinical Requirements Checklist
Last Reviewed & Revised 10/01/2019

NAME: _____
(Please Print) **(Last)** **(First)** **(MI)** **Student ID #**

EMAIL ADDRESS: _____

This checklist is being provided to assist you in completing the documents **required** for the clinical experience component of the program (HIT 60 *Professional Practice Experience* or HIMS 455B *Advanced Professional Practice Experience*).

Submit **copies** of all original records together in a large manila envelope by the designated deadline. Incomplete packets will not be accepted. All materials will be verified and become the property of Shasta College and will not be returned to the student.

Hand deliver or mail to:
Shasta College Health Sciences Division
Attn: HIT/HIM Administrative Assistant
1400 Market Street, Suite 8204
Redding, CA 96001

Or email to:
hsupconnect@shastacollege.edu

Part 2 Pre-Enrollment Clinical Requirements Check-Off List: Steps F through I

☐ **F. Influenza Vaccine for current Influenza season (September through April)**

☐ **G. Tuberculosis (TB) Screening Results & Form– 2nd step of the 2-Step Process (continued)**

IMPORTANT: *If you have submitted a QuantiFERON Gold TB blood test or chest x-ray with your Part 1 Packet, please disregard this step.*

- Complete the TB Screening form and attach the second Tuberculosis screening results within the time frame applicable to your start semester as specified above.

WARNING: Tuberculosis test must be done before, or a minimum of 30 days after, any live vaccination (MMR, Varicella) to avoid false positive.

☐ **H. Physical Examination** must be obtained within 6 months prior to enrollment. Must be documented on the Shasta College Health Sciences "Health Data & Physical Examination" form.

☐ **I. Criminal Background Check & Drug Screening –** initiate process online at www.coeusglobal.com/shastacollege; complete the drug screening at a designated facility within the allotted timeframe. Visit the Health Sciences Background Check & Drug Screening Instruction page for more information.

Student Signature: _____ Date Submitted: _____

Make a personal copy of all records prior to submission to Health Sciences office.
If you have questions, contact the Health Sciences office at (530) 339-3600

Tuberculosis Screening

As per Health Sciences Program Policy - Clinical Requirements, the result of a Two-Step TB screening is required as part of enrolling in a Health Sciences program.

Complete and submit this form with healthcare provider documentation of results attached.

STOP! If you have ever had a positive PPD which required you to have a QuantiFERON Gold TB test or chest x-ray, **you must not** take further PPD tests. Please refer to the Clinical Requirements policy and/or talk with your healthcare provider or Health Services staff for more information. If you have had a BCG vaccine, you may be eligible to use the QuantiFERON Gold TB test instead of x-ray and medical clearance.

Name: _____ Age: _____ Date: _____

Student ID#: _____ Date of Birth: _____

Phone #: _____ Email: _____

NEW STUDENTS:

Date Administered #1: _____ **Result:** ☐Positive ☐Negative

Date Administered #2: _____ **Result:** ☐Positive ☐Negative

Attach a copy of the 2nd TB screening administration and interpretation form from your health care provider.

I am at least 18 years of age and verify that I have completed the 2-Step Process for Tuberculosis Screening with 2 negative test results within the prior 12 months, the second of which is within 6 months prior to enrollment in my Health Science program (or within 90 days of starting clinical for the NA/HHA program only).

_____ **Date:** _____

(Student Signature)

CONTINUING STUDENTS:

Date Administered: _____ **Result:** ☐Positive ☐Negative

Attach a copy of the TB screening administration and interpretation form from your health care provider.

I am at least 18 years of age (under 18 requires written parental consent) and verify that I have completed a Tuberculosis Screening Skin Test.

_____ **Date:** _____

(Student Signature)

Part I: To be completed by Student:

Indicate program of application:	
☐ Associate Degree Nursing (RN)	☐ Medical Scribe
☐ Dental Hygiene (DH)	☐ Nursing Assistant/Home Health Assistant (NA/HHA)
☐ Health Information Technology (HIT)	☐ Pharmacy Technician
☐ Health Information Management (HIM)	☐ Physical Therapist Assistant
☐ Medical Assisting (MA)	☐ Vocational Nursing (LVN)

Applicant information:				
Last Name	First Name		MI	Maiden
Address	City		State	Zip
Email Address	Birth date	Gender M F		
Phone (day)	Phone (eve)		Phone (cell)	

Person to notify in case of emergency:			
Full Name		Relationship	
Address – Number & Street	City	State	Zip
Home Phone	Work Phone	Cell	

HEALTH HISTORY

Please rate you current health status: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Certain minimum physical abilities and characteristics are required in health sciences professions. Do you have any condition that would interfere with your ability to perform the minimum technical skills standards for the program to which you are applying?

☐ Yes ☐ No If yes, explain: _____

_____

Are you pregnant? ☐ Yes ☐ No If yes, due date: _____

Allergies/sensitivities (i.e. medications, foods, Latex/Powder): Please List: _____

_____

Do you have any lifting restrictions: ☐ Yes ☐ No If yes, explain: _____

_____

The information provided is true and correct to the best of my knowledge. I am aware that any change in my physical or mental health, including pregnancy, during the program may require that I obtain medical clearance to continue in the program.

Student Signature: _____ Date: _____

HEALTH DATA & PHYSICAL EXAM FORM (continued)
FOR HEALTH CARE OCCUPATIONS

Applicant Name:	Date:

Part II: To be completed by health care provider

□ I have reviewed the student's Technical Standards Disclosure form

Does your examination of the student reveal any limitations in the following:			
SPINE: □ Yes or □ No	LIFTING: □ Yes or □ No	PROLONGED STANDING: □ Yes or □ No	
PROLONGED SITTING: □ Yes or □ No		BENDING: □ Yes or □ No	□ **NO LIMITATIONS OF ANY TYPE**

Based upon today's exam (which includes all body systems) and the disclosed health history, does this student have any health condition that would create a hazard to self or others, or limit their ability to provide health & patient care and/or services?

□Yes □ No □ Any health condition is under observation and/or treatment and does not create a hazard

If yes, explain:

Physician or Approved Licensed Health Professional Information:	
Agency or Clinic providing service (*Name & Address or Facility Stamp*)	
Printed Name	Title
Signature	Date