# Medical Assisting Program - Part 2 Enrollment Packet Check List

This checklist is provided to assist you in completing the Medical Assisting Part 2 Enrollment Packet. Please use this as a guide as you complete the program's clinical requirements and collect the official documents that are required prior to enrollment into the second semester of the MA program. **Submit copies of all forms to the Health Sciences Division Office. Records will not be accepted separately.**

| Last Name | First Name | MI |
|---|---|---|
| | | |

☐ **C. Immunizations -** Complete the Clinical Requirements Checklist form and submit copies of your original vaccine record or lab test results of titers showing immunity for:

- Tetanus/Diphtheria/Pertussis (TDaP)
- Measles/Mumps/Rubella (MMR)
- Varicella
- Hepatitis B ***can take up to 6 months to complete – DO NOT WAIT TO OBTAIN RECORDS***

**STOP!** – Do not complete steps D – G until directed by the Health Sciences Division.

☐ **D. Technical Standards -** Carefully read the Technical Standards form and initial each technical standard if you can comply with the standard. This a self-assessment to be completed by you. After completing, please **present a copy for review by your healthcare provider at the time of your physical examination**.

☐ **E. Physical Examination -** Must be within 6-months of enrolling into second semester of the program. The results of the exam must be documented on the Shasta College *Health Data & Physical Exam* form.

☐ **F. TB Screening – 2-Step Process**

- The first TB screening must be completed within 12 months of enrollment in second semester. The second TB screening must be completed within 6 months of enrollment in second semester. Fill out the "TB Screening Form – 2-Step Process" form and attach TB screening results.
- If you have had a past positive TB Screening, submit documentation of either a Quantum Gold TB blood test within the past year or a chest x-ray within the past two years. Attach results to the "TB Questionnaire – Confidential" form (available in the Health Sciences office).

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

☐ **G. 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.

**Note:** All materials, including copies of immunization documentation, become the property of Shasta College and cannot be returned to the students.

**IMPORTANT:** Documentation of all the above requirements and results must be on file and submitted as complete to the Health Sciences Office by deadline provided by the Health Sciences Division. **While failure to meet these requirements does not disqualify a student from any of our healthcare programs, it will limit the opportunity to participate in the clinical experiences that are required, and therefore, make it impossible to complete the program.**

**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

**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.<br>ⓘ **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.<br>**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<br>**OR** | Date #1 _____ Date #2 _____ |
| **B.** Proof of quantitative IgG titer showing positive/immune to Varicella<br>**If titer shows as **negative OR equivocal immunity**, proceed to Option 1 or 2. | Date _____ Results _____ |
| **Options<br>You must either:<br>***1)* provide proof of having previously received the original 2-dose vaccination series and having received one (1) booster after your negative titer<br>**OR**<br>***2)*** if you have no previous records, proof of obtaining the 2-dose series after your negative titer | ***Option 1:*** Original Series given:<br>Date #1 _____ Date #2 _____<br>Date of Booster: _____<br>***Option 2:*** Series given:<br>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<br>**OR** | Date #1 _____ Date #2 _____ |
| **B.** Proof of quantitative IgG titer showing positive/immune to Measles, Mumps, and Rubella<br><br>**If titer shows as **negative OR equivocal immunity**, proceed to Option 1 or 2. | Measles: Date _____ Result _____<br>Mumps: Date _____ Result _____<br>Rubella: Date _____ Result _____ |
| **Options<br>You must either:<br>***3)* provide proof of having previously received the original 2-dose vaccination series and having received one (1) booster after your negative titer<br>**OR**<br>***4)*** if you have no previous records, proof of obtaining the 2-dose series after your negative titer | ***Option 1:*** Original Series given:<br>Date #1 _____ Date #2 _____<br>Date of Booster: _____<br><br>***Option 2:*** Series given:<br>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.<br>• **CDC standard recommendations are for series to be given at 0, 1, and 6 months.**<br>• **CDC minimum requirements allow for series to be given at 0, 1, and 4 months.**<br>**OR** | Date # 1 _____<br>Date # 2 _____<br>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.<br>**OR** | Date # 1 _____ Result _____<br>**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.<br>**OR** | Date _____ Results _____<br>**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 _____<br>**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.**<br><br>***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: |

In the interest of your own personal safety and the safety of your patients, there are significant requirements that must be met before your admission to the program is finalized. The attendance requirements and stamina demands requires the Health Sciences student to be in good physical and mental health. Please read this form carefully and initial each technical issue standard if you can comply with the standard. When complete, please sign, date and return original in your Pre-Enrollment Clinical Requirements Packet. **Note: This is a self-assessment – to be completed by you, not a health care provider.** *Applicants must present a copy of their completed Technical Standards to their healthcare provider for review at the time of the physical examination*. **Please see the Health Sciences Dean if you require an accommodation or cannot comply with the standard.**

| Issue | Description | Standard/Physical Requirement | Initials |
|---|---|---|---|
| **Mobility** | Physical ability, flexibility, strength and stamina | Standard work day requires various abilities including standing, walking, sitting, bending, flexing, lifting, twisting, stooping, kneeling, reaching, stretching, pushing and pulling to gather and stock supplies, operate equipment (computers, various types of medical devices, hospital beds, etc.), and perform required functions of patient care. Often must lift, carry or move objects weighing up to 40 pounds. Ability to assist patient position, transfer, or transport requiring lifting in excess of 40 pounds. | |
| **Motor Skills** | Physical ability, coordination, dexterity | Gross and fine motor abilities sufficient to perform required functions of patient care; hand-wrist movement, hand-eye coordination, and simple firm grasping required for fine motor-skills and manipulation; fine and gross finger dexterity required; | |
| **Comprehension** | Comprehend and process information; perform algebraic and complex calculations | Engage in written and oral directives related to patient care, retaining information given by faculty/ healthcare providers to assimilate and apply to patient care; comprehend and process instructions accurately; perform mathematical functions/calculations regarding medication administration. | |
| **Tactile** | Use of touch | Normal tactile feeling required. Sensitivity to heat, cold, pain, pressure, etc. | |
| **Hearing** | Use of auditory sense | Ability to hear and interpret many people and correctly interpret what is heard; i.e., healthcare provider, or supervisor orders whether verbal or over telephone, patient complaints, physical assessment (especially heart and other body sounds), fire and equipment alarms, etc. | |
| **Visual** | Use of sight | Acute visual skills necessary to detect signs and symptoms, body language of patients, color of gingival tissues, wounds, drainage, and possible infections anywhere. Interpret written words accurately, read characters and identify colors on the computer screen. Ability to read small print on medication and medical equipment. | |
| **Critical Thinking** | Ability to problem solve | Integrate information through critical thinking based on information gathered from patients during clinical sessions/ rotations, and during class sessions that are applied in the clinical process. | |
| **Communication** | Speak, read, write, & use English language effectively. Communicate effectively in interactions with others verbally, nonverbally & in written form | Effectively interacts with the environment and other persons. Fluent in English. Ability to communicate with wide variety of people and styles and to be easily understood. Reading, writing, recording, and documenting critical patient information required. | |
| **Behavioral** | Emotional & mental stability | Functions effectively under stress; flexible, concern for others; able to provide safe patient care and work in environment with multiple interruptions and noises, distractions, and unexpected patient needs. | |

**Print Name** _____ **Student Signature** _____ **Date** _____

## 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 subjective/objective exam 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<br>(*Name & Address or Facility Stamp*) | |
| Printed Name | Title |
| Signature | Date |

# 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: _____

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## 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)*

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## 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)*