□ Nursing
□ Radiography
□ Respiratory Therapy
□ CNA
□ Biomedical Engineering
□ Paramedic Science

Semester/Year_____

COUNTY COLLEGE OF MORRIS
Health Programs MEDICAL HISTORY AND PHYSICAL EXAMINATION

TO BE COMPLETED AND SIGNED BY STUDENT/FACULTY:

Last Name_____First Name_____MI_____Student ID_____

Student Email_____Phone_____Date of Birth_____Age_____

Drug Allergies _____Food Allergies/Intolerance _____

Does student require EpiPen? □ Yes □ No Has student been trained in its use? □ Yes □ No

Medications (Please include prescription medications and any over-the-counter medications taken daily)_____

_____

Past Medical History_____

_____

Name of Emergency Contact_____Relationship_____

Home Phone_____Cell/Work Phone_____

Signature of Student/Faculty_____Date_____

TO BE COMPLETED AND SIGNED BY LICENSED HEALTHCARE PROVIDER: The information requested by the College is strictly for the use of authorized personnel and will not be released without the student's consent.

Male_____ Female_____ Height_____ Weight_____ Blood Pressure_____

Heart Rate_____ Hearing within Normal Limits □Yes □No Vision Right 20/_____ Left 20/_____

Corrective Lenses □ Yes □ No Color Blind □ Yes □ No

System	Satisfactory	Unsatisfactory	Details if Unsatisfactory
HEENT			
Respiratory			
Cardiovascular			
Gastrointestinal			
Hernia			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			

Student/Faculty is medically qualified to wear a N95 Respirator. □ Yes □ No

Student/Faculty is cleared for all clinical activities without limitations. □ Yes □ No

If no, please explain why_____

Licensed Healthcare Provider's Name _____Date of Exam_____
Print

Signature of Licensed Healthcare Provider_____Phone_____

Address _____

□ Nursing □ CNA Semester/Year_____
□ Radiography □ Biomedical Engineering
□ Respiratory Therapy □ Paramedic Science

COUNTY COLLEGE OF MORRIS
Health Programs IMMUNIZATION RECORD

Last Name_____ First Name_____ MI_____ Student ID_____

Student Email_____ Phone_____ Date of Birth_____ Age_____

TO BE COMPLETED AND SIGNED BY A LICENSED HEALTHCARE PROVIDER: All students must have titers* drawn. <u>All laboratory reports</u> must be attached for Rubeola (Measles), Mumps, Rubella, Varicella and HBsAb titers. Equivocal findings are documented as negative immunity.

***Past Titer Results are acceptable. Titers do not need to be repeated.**

Test	Drawn	IgG Titer Value	Revaccination* Date
Rubeola (Measles)	Date_____	Value_____ □ Positive □ Negative	(Re)vaccination #1 Date_____ (with documented series) (Re)vaccination #2 Date_____ (without documented series)
Mumps	Date_____	Value_____ □ Positive □ Negative	(Re)vaccination #1 Date_____ (with documented series) Revaccination #2 Date_____ (without documented series)
Rubella	Date_____	Value_____ □ Positive □ Negative	Revaccination #1 Date_____ (If Titer is Negative or Equivocal)
Varicella	Date_____	Value_____ □ Positive □ Negative	(Re)vaccination #1 Date_____ (with documented series) (Re)vaccination #2 Date_____ (without documented series)
Hepatitis B (HBsAb)	Date_____	Value_____ □ Immune □ Not-Immune	If HBsAb titer shows immunity, the student does not need to complete the three Hepatitis vaccine series. If HBsAb titer **<u>does not</u>** show immunity, three (3) documented doses of Hepatitis B vaccine must be presented or administered.
Hepatitis B	**Dates of Vaccinations** Three (3) doses of Hepatitis B vaccine administered intramuscularly at 0, 1 and 6 months.		
	#1	**#2**	**#3**

*Based on CDC recommendations for Healthcare Professionals

Tdap	Date_____	Student must have received a Tdap vaccine at 11 years of age or older.

Licensed Healthcare Provider's Name _____ Date of Exam_____
Print

Signature of Licensed Healthcare Provider_____

Address_____ Phone_____

_____

6.1.18 New
9/19/19 revised

□ Nursing □ CNA Semester/Year_____
□ Radiography □ Biomedical Engineering
□ Respiratory Therapy □ Paramedic Science

COUNTY COLLEGE OF MORRIS
HEALTH PROGRAMS ANNUAL TUBERCULOSIS SCREENING

Last Name_____ First Name_____ MI_____ Student ID_____

Student Email_____ Phone_____ Date of Birth_____ Age_____

TO BE COMPLETED AND SIGNED BY A LICENSED HEALTHCARE PROVIDER: Either a Mantoux TB (PPD) skin test OR an interferon gamma release assay (IGRA) blood test such as QuantiFERON Gold® or T-SPOT® is acceptable. A two-step PPD is necessary unless a PPD was done in the last calendar year. If a one-step PPD was done, documentation of the previous one-step done within the past calendar year must be attached. PPD RESULTS MUST BE RECORDED IN mm

Two-Step PPD (Mantoux) (Date Read must be within 72 hours)

PPD #1 Date Administered_____ Site _____ Date Read*_____ Result _____

PPD #2 (administered 1 to 3 weeks after PPD #1) is required unless student provides proof of a previous negative PPD within 1 year of the date of PPD #1 OR provides a negative T-Spot or QuantiFERON result from previous year.

PPD #2 Date Administered_____ Site _____ Date Read*_____ Result _____

*Date Read Must Be Within 72 hours

One-Step PPD (Mantoux)
Documentation of previous one-step done within the past calendar year must be attached.

PPD #1 Date Administered_____ Site _____ Date Read*_____ Result _____

*Date Read Must Be Within 72 hours

OR

IGRA (QuantiFERON)—TB Gold® or T-Spot® Blood Test Date Reported_____ Result_____
Lab Report Must Be Attached

PPD or QuantiFERON® or T-Spot® Positive Findings

Positive Result: If positive, a negative post-positive chest x-ray is required. This is a one-time only requirement as long as student is asymptomatic. An IGRA blood test is recommended for subsequent tuberculosis screening.

Chest x-ray has been documented post-positive result? ☐ Report Date_____ **Report Must Be Attached**

☐ Normal Chest x-ray

☐ Abnormal Chest x-ray ☐ Patient was/is treated with prophylactic medication. Date treatment started

Licensed Healthcare Provider's Name_____ Date_____

Signature of Licensed Healthcare Provider_____

Address _____ Phone_____

_____

□ Nursing □ CNA Semester/Year_____
□ Radiography □ Biomedical Engineering
□ Respiratory Therapy □ Paramedic Science

COUNTY COLLEGE OF MORRIS
Health Programs ANNUAL INFLUENZA VACCINATION

Last Name_____First Name_____MI_____Student/Faculty ID_____

Student/Faculty Email_____Phone_____Date of Birth_____Age_____

TO BE COMPLETED AND SIGNED BY A LICENSED HEALTHCARE PROVIDER
If documentation is being sent that includes all the information below, then indicate "See attached".

Date of Vaccine Administration_____

Manufacturer_____ Product Name_____

Lot_____ Expiration Date_____

Dose_____ Injection Site_____

Licensed Healthcare Provider's Name _____Title_____
Print

Signature of Licensed Healthcare Provider_____

Address_____Phone_____

_____

NOTE:
For students admitted in the fall, vaccination must be administered by **October 1st** each year.

For students admitted in the spring, vaccination must be administered by **December 31st if not previously vaccinated** prior to admission and by October 1st for each year thereafter.

6.1.18 New
9.16.2020 Rev

□ Nursing □ CNA Semester/Year_____
□ Radiography □ Biomedical Engineering
□ Respiratory Therapy □ Paramedic Science

COUNTY COLLEGE OF MORRIS
Health Programs URINE DRUG SCREENING

Last Name_____First Name_____MI_____Student ID_____

Student Email_____Phone_____Date of Birth_____Age_____

A 13-panel drug screen is mandatory for all students doing their clinical rotations at healthcare facilities. The screen includes the drugs listed below.

Amphetamines/ Methamphetamine	Barbiturates	Benzodiazepines	Cannabinoids
Benzoylecgonine- Cocaine Metabolite	Opiates	Phencyclidine	Methadone
Propoxyphene	MDMA/MDA	Methaqualone	Meperidine
Tramadol			

Failure to submit to drug screening will result in dismissal from the program. The drug screening MUST be completed at **FastER Urgent Care** (flyer attached). The cost is $70 payable on the day of testing. The student must bring this form to FastER Urgent Care and have it signed below by a FastER Urgent Care representative and submit it to the Administrative Assistant for Health Professions. Test results are sent directly to the College by FastER Urgent Care. For questions, students should refer to the Student Handbook or contact the Administrative Assistant for Health Professions.

As part of my pre-clinical requirement to ensure I am physically able to perform the clinical component of my program, I am required to provide a urine sample for an 13-panel drug screen to determine my status for illegal drug use.

I, _____, consent to providing a sample of my urine to be tested for drug content at **FastER Urgent Care.**

TO BE SIGNED BY A FastER URGENT CARE REPRESENTATIVE

Representative's Name _____Date of Test_____
Print

Signature of Representative_____

Address_____Phone_____

□ Nursing □ CNA Semester/Year_____
□ Radiography □ Biomedical Engineering
□ Respiratory Therapy □ Paramedic Science

COUNTY COLLEGE OF MORRIS
Health Programs ATTESTATION OF HEALTH INSURANCE COVERAGE

Last Name_____First Name_____MI_____Student ID_____

Student Email_____Phone_____Date of Birth_____Age_____

I, _____, attest that as required by County College of Morris, I have a

Print Full Name

current health insurance plan which I will maintain through the entirety of my enrollment in the professional phase of the Nursing, Radiography, Respiratory Therapy and/or other health-related program that require participation in a clinical experience. I understand that at any time I may be required to present proof of my health insurance plan.

Student Signature_____ Date_____

COUNTY COLLEGE OF MORRIS
Health Programs AUTHORIZATION FOR MEDICAL RELEASE

I, _____, authorize County College of Morris to release and disclose

Print Full Name

any and/or all pertinent medical information contained in my health clearance packet to the clinical facility and/or regulating agency that requires this information as a condition of my assignment to the facility.

This document will remain in effect through the entirety of my enrollment in the professional phase of the Nursing, Radiography, Respiratory Therapy and/or other health-related program for up to a two-year period from the date of signature.

Student Signature_____ Date_____

□ Nursing □ CNA Semester/Year:_____
□ Radiography □ Biomedical Engineering
□ Respiratory Therapy □ Paramedic Science

COUNTY COLLEGE OF MORRIS

CRIMINAL HISTORY BACKGROUND CHECK AND DRUG and ALCOHOL SCREENING
STUDENT ACKNOWLEDGEMENT FOR STUDENTS IN THE CLINICAL PHASE OF THE HEALTH PROFESSIONS PROGRAMS

I acknowledge that I have received written notification informing me that all students enrolled in clinical courses will be required to submit to a Criminal History Background Check (CHBC) and Urine Drug Screening as mandated by the clinical affiliation agreements.

The CHBC will occur on an annual basis. If there is a record found or a positive result, admission into the professional phase of the program may be denied. If at any time after acceptance into the professional phase of the program a student has a positive CHBC, it may result in dismissal from the program.

It is the policy of the Nursing, Radiography and Respiratory Therapy Programs that students report any arrest or conviction immediately to the department chairperson and that this information will be reported to the security services director (or other designated person) at the clinical site to which the student is assigned.

An 13-panel Urine Drug Screening will be performed upon acceptance into the clinical phase of the program. In the event of behavior deemed inappropriate or suspicious in any clinical course, the College reserves the right to refer the student for a random drug and alcohol screen. All costs of initial and additional screenings will be incurred by the student. Positive results may be cause for immediate dismissal from the program. Refusal to submit to drug and alcohol screenings will result in dismissal from the program. Campus Regulations regarding alcohol and drugs also apply.

Reinstated students must have a repeat CHBC and Urine Drug Screening completed upon re-entry into the program.

When a graduate applies for licensure as a registered nurse, radiologic technologist or respiratory therapist in New Jersey, another CHBC will be performed. If the CHBC reveals a conviction, a review of the offense by the licensing and/or credentialing board may be required and may delay the licensure or credentialing process.

_____ _____
Signature Date

_____ _____ _____
Print Name Student ID # Program

□ Nursing □ CNA Semester/Year_____
□ Radiography □ Biomedical Engineering
□ Respiratory Therapy □ Paramedic Science

COUNTY COLLEGE OF MORRIS
Health Programs COVID-19 VACCINATION ATTESTATION

Last Name_____First Name_____MI_____Student/Faculty ID_____

Student/Faculty Email_____Phone_____Date of Birth_____Age_____

I,_____, attest that (check only one box):
Print Full Name

☐ I am fully vaccinated.

"Fully vaccinated" means a person has received all recommended doses in their primary series of either the Moderna, Pfizer, or Johnson & Johnson COVID-19 Vaccine and a booster dose when eligible.

Date(s) of Vaccine Administration_____

COVID-19 Vaccine Manufacturer_____

☐ I am partially vaccinated.

I received the first dose of a two-dose COVID-19 vaccine on_____and expect to receive the second dose on_____.
Date *Date*

I received the primary series on _____and expect to receive the booster on _____.
Date *Date*

☐ I am unvaccinated.

I have not received a COVID-19 vaccine.

***Fully vaccinated students must submit a copy of their COVID-19 Vaccine Record Card to clinicalclearance@ccm.edu.**

I confirm that the information I have provided is accurate and truthful to the best of my knowledge.

Student Signature_____ Date_____

NOTE:
Due to the ongoing changes related to the COVID-19 pandemic, additional requirements may be imposed by clinical institutions related to COVID-19 vaccination, screening, and testing. Students will be notified of these requirements as they occur. Documentation to support a student's medical or religious exemption should be provided directly to the clinicalclearance@ccm.edu or clinical facility as required.

FastER Urgent Care is a located across the street from the Alfred Vail School at 130 Speedwell Avenue on the corner of Mill Road in Morris Plains. We provide walk-in no appointment needed medical care to children and adults for a wide range of illness and injuries including:

- Cough/Colds/Flu/Strep Throat
- Ear Aches
- Fractures/Dislocations
- Sprains/Strains
- Lacerations, Burns and Skin Infections
- Urinary Tract Infections
- Gyn problems and STD Testing
- Vomiting/Diarrhea
- School/Camp/Sports/Work and Routine Physicals

We have onsite x-ray and rapid testing for strep, pregnancy, and flu, and full lab services

Open Monday-Friday 8am-8pm*

Saturday and Sunday 8am-4pm*

Major Holidays 9am-1pm

***Drug Testing stops at 5pm on weekdays and 1pm on weekends**

New Jersey Department of Health

Symptom Assessment for Pulmonary Tuberculosis (TB)

Name *(Last, First, MI)*		Birthdate *(mm/dd/yyyy)*
Street Address		Telephone Number
City	State	Zip Code

Date of Symptom Assessment *(mm/dd/yyyy)*

TB-Like Symptoms *(Check all that apply)*:

- ☐ Productive Cough of Undiagnosed Cause (more than 3 weeks in duration)
- ☐ Coughing Up Blood (Hemoptysis)
- ☐ Unexplained Weight Loss (10 pounds or greater without dieting)
- ☐ Night Sweats (regardless of room temperature)
- ☐ Unexplained Loss of Appetite
- ☐ Very Easily Tired (Fatigability)
- ☐ Fever
- ☐ Chills
- ☐ Chest Pain

If any symptoms are reported a chest radiograph and medical evaluation is needed.

☐ **No TB-Like Symptoms Reported or Observed**

Name of Licensed MD/RN *(Print)*	
Signature of Licensed MD/RN	Date

Atlantic Health System

ATLANTIC HEALTH SYSTEM
N-95 Respirators ONLY

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire

PLEASE COMPLETE QUESTIONNAIRE AND BRING TO OCCUPATIONAL MEDICINE SERVICE

To the employee:

Can you read ☐ Yes ☐ No

As your employer, AHS must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, no AHS manager or supervisor is permitted look at or review your answers. You may deliver this questionnaire personally to the Occupational Medicine Service office at your site or send it marked confidential through interoffice mail where it will be reviews by a designated health care professional.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (***please print***).

1. Today's Date: _____
2. Your Name and SS#: _____
3. Your Age (to nearest year): _____
4. Sex: ☐ Male ☐ Female
5. Your Height: _____ ft. _____ in.
6. Your Weight: _____ lbs.
7. Your Department/Job Title: _____
8. Telephone numbers (Including area code): Work _____ Home _____
   Cell _____
9. **The best time to reach you by phone between the hours of 7:00 am and 3:00 pm:** _____
   At which number (Circle): Work Home Cell.

10. Has your employer told you how to contact the health care professional who will review this questionnaire (check one): ☐Yes ☐ No (You ***may contact your Site OMS Office)***
11. Check the type of respirator you will use (you can check more than one category):
    a. ☐ N-95, R, or P disposable respirator (filter-mask, **non-cartridge** type only).
    b. ☐ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator before?: **☐ Yes ☐ No**
    If "yes," what type(s): _____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month: **☐ Yes ☐ No**
2. Have you *ever had* any of the following conditions?
   - **a.** Seizures (fits): **☐ Yes ☐ No**
   - b. Diabetes (sugar disease): **☐ Yes ☐ No**
   - **c.** Allergic reactions that interfere with your breathing: **☐ Yes ☐ No**
   - d. Claustrophobia (fear of closed-in places): **☐ Yes ☐ No**
   - **e.** Trouble smelling odors: **☐ Yes ☐ No**

If you answer yes to any above question please explain.

3. Have you *ever had* any of the following pulmonary or lung problems?

a. Asbestosis:	☐ Yes ☐ No
b. Asthma:	☐ Yes ☐ No
c. Chronic bronchitis:	☐ Yes ☐ No
d. Emphysema:	☐ Yes ☐ No
e. Pneumonia:	☐ Yes ☐ No
f. Tuberculosis:	☐ Yes ☐ No
g. Silicosis:	☐ Yes ☐ No
h. Pneumothorax (collapsed lung):	☐ Yes ☐ No
i. Lung cancer:	☐ Yes ☐ No
j. Broken ribs:	☐ Yes ☐ No
k. Any chest injuries or surgeries:	☐ Yes ☐ No
l. Any other lung problem that you've been told about:	☐ Yes ☐ No

If you answer yes to any above question please explain and list any medical attention you have received:

4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?

a. Shortness of breath:	☐ Yes ☐ No
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline:	☐ Yes ☐ No
c. Shortness of breath when walking with other people at an ordinary pace on level ground:	☐ Yes ☐ No
d. Have to stop for breath when walking at your own pace on level ground:	☐ Yes ☐ No
e. Shortness of breath when washing or dressing yourself:	☐ Yes ☐ No
f. Shortness of breath that interferes with your job:	☐ Yes ☐ No
g. Coughing that produces phlegm (thick sputum):	☐ Yes ☐ No
h. Coughing that wakes you early in the morning:	☐ Yes ☐ No
i. Coughing that occurs mostly when you are lying down:	☐ Yes ☐ No
j. Coughing up blood in the last month:	☐ Yes ☐ No
k. Wheezing:	☐ Yes ☐ No
l. Wheezing that interferes with your job:	☐ Yes ☐ No
m. Chest pain when you breathe deeply:	☐ Yes ☐ No
n. Any other symptoms that you think may be related to lung problems:	☐ Yes ☐ No

If you answer yes to any above question please explain and did you seek medical attention:

5. Have you *ever had* any of the following cardiovascular or heart problems?

a. Heart attack:	☐ Yes ☐ No
b. Stroke:	☐ Yes ☐ No
c. Angina:	☐ Yes ☐ No
d. Heart failure:	☐ Yes ☐ No
e. Swelling in your legs or feet (not caused by walking):	☐ Yes ☐ No
f. Heart arrhythmia (heart beating irregularly):	☐ Yes ☐ No
g. High blood pressure:	☐ Yes ☐ No
h. Any other heart problem that you've been told about:	☐ Yes ☐ No

If you answer yes to any above question please explain and did you seek medical attention:

6. Have you *ever had* any of the following cardiovascular or heart symptoms?

a. Frequent pain or tightness in your chest: ☐ Yes ☐ No
b. Pain or tightness in your chest during physical activity: ☐ Yes ☐ No
c. Pain or tightness in your chest that interferes with your job: ☐ Yes ☐ No
d. In the past two years, have you noticed your heart skipping or missing a beat: ☐ Yes ☐ No
e. Heartburn or indigestion that is not related to eating: ☐ Yes ☐ No
f. Any other symptoms that you think may be related to heart or circulation problems: ☐ Yes ☐ No

If you answer yes to any above question please explain and list any medical attentions you may have received:

7. Do you *currently* take medication for any of the following problems?

a. Breathing or lung problems: ☐ Yes ☐ No
b. Heart trouble: ☐ Yes ☐ No
c. Blood pressure: ☐ Yes ☐ No
d. Seizures (fits): ☐ Yes ☐ No

If yes, please list medications:

8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, go to question 9 :)

a. Eye irritation: ☐ Yes ☐ No
b. Skin allergies or rashes: ☐ Yes ☐ No
c. Anxiety: ☐ Yes ☐ No
d. General weakness or fatigue: ☐ Yes ☐ No
e. Any other problem that interferes with your use of a respirator: ☐ Yes ☐ No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: ☐ Yes ☐ No

Cleared: Yes No

Date: _____

Signature of MD/NP: _____