### GET YOUR CLINICAL VACCINATIONS TODAY

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<th>Who Must Comply</th>
<th>Compliance Requirements</th>
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<td>Varicella</td>
<td>All nursing students</td>
<td>Proof of vaccination with 2 doses of vaccine; titer demonstrating immunity; or signed waiver</td>
<td>Before the start of core nursing classes</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (MMR)</td>
<td>All new students born after January 1, 1957</td>
<td>Proof of vaccination with 2 doses of vaccine; titer demonstrating immunity; or signed waiver</td>
<td>Before the start of core nursing classes</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Student who wish to take vaccine.</td>
<td>Proof of completion of a Hepatitis B series or signed waiver</td>
<td>Before the start of core nursing classes</td>
</tr>
<tr>
<td>Tuberculosis Skin Test²</td>
<td>All new international students</td>
<td>Proof of negative test results in the United States</td>
<td>Before the start of core nursing classes</td>
</tr>
</tbody>
</table>

- Hope College of Arts & Sciences Immunization Record completed and signed by a physician or nurse.
- Copies of shot record.
- Copies of laboratory test results demonstrating immunity.
- **Clinical Forms**
Clinical Requirements

Clinical begin soon. Please make sure you are in compliance with the following requirements:

☐ Physical Exam and Immunization:

☐ *Tuberculin skin test within the past 12 months or documentation as a previous positive reactor and a chest x-ray taken within the past 12 months*

☐ *Proof of measles and rubella immunity by positive antibody titers or 2 doses of MMR; and varicella immunity, by positive history of chicken pox or proof of varicella immunization*

☐ *Proof of hepatitis B immunization or completion of a certification of declination of vaccine*

☐ *Proof of influenza vaccine (Flu Season is October to March)*

☐ Negative drug screen (obtain official chain of custody form from office)

☐ FDLE Level II Background Check (VECHS) through Statutory Fingerprinting & Notary, Inc. (Obtain official form from office)

☐ Financial obligations to HCAS are current.

☐ Current CPR certification (BLS)
Equipment/Attire Requirements

1. Stethoscope
2. Blood Pressure Cuff
3. Watch with Second Hand
4. Bandage Scissors
5. School ID
6. Lab Coat, White (*optional*)
7. Uniforms: Top-white with School Logo, Bottom-blue
8. Shoes, White
9. Protective Eyewear
10. Undergarments – No colors or prints
11. Short finger nails
PHYSICAL EXAMINATION

Student’s Name _______________________________ Date of Birth ____________

Last   First

Address: _______________________________ Examination Date: __ / __ / __

□ Male □ Female   Height _____  Weight _____  Pulse _____  BP _____ / __

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal Findings</th>
<th>Initials*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes/Ears/Nose/Throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymph Nodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitalia (males only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Clearance

□ Based on review of the patient’s medical history, immunization records, and physical examination performed in my office, it is my impression that the above-named student is cleared and FREE FROM COMMUNICABLE DISEASE

□ Clear after completing evaluation/rehabilitation for: ________________________________

□ Not cleared for: ___________________________  Reason: ___________________________

Healthcare Provider Printed Name: ___________________________ Date: ______________

Healthcare Provider Signature: ________________________________

Office Phone Number: (____ ) ___________________________
**SECTION A**

**MEASLES, MUMPS AND RUBELLA**
Students must have received two doses of MMR vaccine or have serologic immunity to measles and rubella.

- **MMR vaccine:** Dose #1 _____/_____/______ Dose #2 _____/_____/______
- **Date of Measles titer** _____/_____/______ *lab result must be attached  Immune: Yes____ No ______
- **Date of Rubella titer** _____/_____/______ *lab result must be attached  Immune: Yes____ No ______

**Varicella**

- **Varicella vaccine:** Dose #1 _____/_____/______ Dose #2 _____/_____/______
- **Varicella IgG Antibody titer:** _____/_____/______ *lab result must be attached  Immune: Yes____ No ______

**Hepatitis B**
Serologic testing is required for hepatitis B surface antibody. Serologic immunity should be tested 1-2 months after completion of the three dose hepatitis B vaccine series.

- **Hepatitis B vaccine:** Dose #1 _____/_____/______ Dose #2 _____/_____/______ Dose #3 _____/_____/______
- **Date of hep B Surface Antibody titer:** _____/_____/______ *lab result must be attached  Immune: Yes____ No ______

**SECTION B**

**TETANUS-DIPHTHERIA**

- **TETANUS/DIPHTHERIA/PERTUSSIS (Tdap**): _____/_____/______  **TETANUS/DIPHTHERIA (TD):** _____/_____/______

**due to the increased risk of pertussis in healthcare settings, we recommend Tdap for healthcare personnel. Tdap is recommended if it has been more than two years since your last TD booster.**

I certify that the information above is complete and accurate to the best of my knowledge:

Healthcare Provider Printed Name: _____________________________ Date: _____________

Healthcare Provider Signature: _____________________________

Questions regarding this mandatory immunization form should be directed to Hope College of Arts & Sciences at 954-532-9614
Mandatory 10 panel Drug Screen

Hope College of Arts and Sciences require ALL students to complete an updated 10 panel drug screen form prior to enrolling into the college.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Device Code</th>
<th>Negative</th>
<th>Presumptive Positive</th>
<th>Not Tested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cocaine</td>
<td>COC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marijuana</td>
<td>THC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opiates/Morphine</td>
<td>OPI/MOR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amphetamines</td>
<td>AMP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>Mamp</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phencyclidine</td>
<td>PCP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>BZO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barbiturates</td>
<td>BAR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methadone</td>
<td>MTD</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Oxycodone</td>
<td>OXY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Propoxyphene</td>
<td>PPX</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I certify that the information above is complete and accurate to the best of my knowledge:

Healthcare Provider Printed Name: ___________________________ Date: __________

Healthcare Provider Signature: ____________________________
NAME: _______________________________________________________

DEPARTMENT: _______________________________________________

Our records indicate that it is time for your tuberculosis screening. These screenings are mandatory and must be completed annually. If you have NEVER had a positive PPD skin test, please complete the section below.

PPD SKIN TEST

Site: ____________________________        Date/Time Given: ________________________

Given By: _______________________        Signature:  ______________________________

Please Print

RESULTS

Date/Time Reading: _______________________ (48 to 72 hours after date given)

Read by: __________________________          Signature: ___________________________

Reading: _____________ (mm) induration

(Must be in mm of induration; redness alone should not be read as a positive)

If you have history of positive skin test, please answer the following questions below:

Do you have any of the following:

- Persistent cough (over three weeks' duration)?
- Night sweats?
- Persistent low-grade fever?
- Fatigue?
- Loss of appetite?
- Coughing up blood?
- Chest pain?

Yes    NO

_________________________  ___________
Employee Signature        Date

If you develop any of the above signs and symptoms, please report to Administration immediately for referral and follow-up

Interpretation of the Mantoux Tuberculin Skin Test

- Measure test results 48 to 72 hours after test is given
- Measure only palpable induration (raised area or induration) across widest area, Not erythema (redness)
- Test should then be repeated at a different site.

- 10 millimeters or more (POSITIVE)
- 5 millimeters
- 5 millimeters
- 0 millimeters

Return Form To:
Hope College of Arts and Sciences
1200 SW 3rd Street, Ste 110
Pompano Beach, FL 33069
Phone: 954-532-9614 – Fax: 754-222-9835
HEPATITIS B IMMUNIZATION REFUSAL FORM

I was given information about hepatitis B virus and hepatitis B vaccine and I had the opportunity to ask questions. My questions were answered.

I understand as a student, due to my exposure to blood or other potentially infectious material, I may be at risk of acquiring hepatitis B virus (HBV). I was given the choice to be vaccinated by a physician of my choice with hepatitis B vaccine; however, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at an increased risk of acquiring hepatitis B. Hope College of Arts and Sciences will not be held responsible in the event I become infected.

________________________________________
Student Name

________________________________________
Student Signature

________________________________________
Date

________________________________________
Clinical Coordinator/Designee

________________________________________
Date
Hepatitis B Vaccine
What You Need to Know

1 Why get vaccinated?
Hepatitis B is a serious disease that affects the liver. It is caused by the hepatitis B virus. Hepatitis B can cause mild illness lasting a few weeks, or it can lead to a serious, lifelong illness.

Hepatitis B virus infection can be either acute or chronic.

**Acute hepatitis B virus infection** is a short-term illness that occurs within the first 6 months after someone is exposed to the hepatitis B virus. This can lead to:
- fever, fatigue, loss of appetite, nausea, and/or vomiting
- jaundice (yellow skin or eyes, dark urine, clay-colored bowel movements)
- pain in muscles, joints, and stomach

**Chronic hepatitis B virus infection** is a long-term illness that occurs when the hepatitis B virus remains in a person’s body. Most people who go on to develop chronic hepatitis B do not have symptoms, but it is still very serious and can lead to:
- liver damage (cirrhosis)
- liver cancer
- death

Chronically-infected people can spread hepatitis B virus to others, even if they do not feel or look sick themselves. Up to 1.4 million people in the United States may have chronic hepatitis B infection. About 90% of infants who get hepatitis B become chronically infected and about 1 out of 4 of them dies.

Hepatitis B is spread when blood, semen, or other body fluid infected with the Hepatitis B virus enters the body of a person who is not infected. People can become infected with the virus through:
- Birth (a baby whose mother is infected can be infected at or after birth)
- Sharing items such as razors or toothbrushes with an infected person
- Contact with the blood or open sores of an infected person
- Sex with an infected partner
- Sharing needles, syringes, or other drug-injection equipment
- Exposure to blood from needlesticks or other sharp instruments

Each year about 2,000 people in the United States die from hepatitis B-related liver disease.

**Hepatitis B vaccine** can prevent hepatitis B and its consequences, including liver cancer and cirrhosis.

2 Hepatitis B vaccine
Hepatitis B vaccine is made from parts of the hepatitis B virus. It cannot cause hepatitis B infection. The vaccine is usually given as 2, 3, or 4 shots over 1 to 6 months.

**Infants** should get their first dose of hepatitis B vaccine at birth and will usually complete the series at 6 months of age.

All **children and adolescents** younger than 19 years of age who have not yet gotten the vaccine should also be vaccinated.

Hepatitis B vaccine is recommended for unvaccinated **adults** who are at risk for hepatitis B virus infection, including:
- People whose sex partners have hepatitis B
- Sexually active persons who are not in a long-term monogamous relationship
- Persons seeking evaluation or treatment for a sexually transmitted disease
- Men who have sexual contact with other men
- People who share needles, syringes, or other drug-injection equipment
- People who have household contact with someone infected with the hepatitis B virus
- Health care and public safety workers at risk for exposure to blood or body fluids
- Residents and staff of facilities for developmentally disabled persons
- Persons in correctional facilities
- Victims of sexual assault or abuse
- Travelers to regions with increased rates of hepatitis B
- People with chronic liver disease, kidney disease, HIV infection, or diabetes
- Anyone who wants to be protected from hepatitis B

There are no known risks to getting hepatitis B vaccine at the same time as other vaccines.
Some people should not get this vaccine

Tell the person who is giving the vaccine:

- If the person getting the vaccine has any severe, life-threatening allergies.
  If you ever had a life-threatening allergic reaction after a dose of hepatitis B vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Ask your health care provider if you want information about vaccine components.

- If the person getting the vaccine is not feeling well.
  If you have a mild illness, such as a cold, you can probably get the vaccine today. If you are moderately or severely ill, you should probably wait until you recover. Your doctor can advise you.

Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of side effects. These are usually mild and go away on their own, but serious reactions are also possible.

Most people who get hepatitis B vaccine do not have any problems with it.

Minor problems following hepatitis B vaccine include:

- soreness where the shot was given
- temperature of 99.9°F or higher

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

Your doctor can tell you more about these reactions.

Other problems that could happen after this vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting and injuries caused by a fall. Tell your provider if you feel dizzy, or have vision changes or ringing in the ears.

- Some people get shoulder pain that can be more severe and longer-lasting than the more routine soreness that can follow injections. This happens very rarely.

- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: www.cdc.gov/vaccinesafety/

What if there is a serious problem?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can’t wait, call 9-1-1 or get to the nearest hospital. Otherwise, call your clinic.

Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at www.vaers.hhs.gov, or by calling 1-800-822-7967.

VAERS does not give medical advice.

The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1-800-338-2382 or visiting the VICP website at www.hrsa.gov/vaccinecompensation. There is a time limit to file a claim for compensation.

How can I learn more?

- Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call 1-800-232-4636 (1-800-CDC-INFO) or
  - Visit CDC’s website at www.cdc.gov/vaccines

Vaccine Information Statement

Hepatitis B Vaccine

10/12/2018 | 42 U.S.C. § 300aa-26