Wisconsin Indianhead Technical College
Health Sciences Programs
Health Form

***Please wait until after program orientation to complete this form**

Student Name: _____ ID: _____

Please check appropriate program:

- ☐ **Dental Assistant** (due the first day of Dental Health and Safety)
- ☐ **Health Information Technology** (due at the start of Professional Practice)
- ☐ **Medical Assistant** (due at the start of 1st semester core classes)
- ☐ **Nursing-Associate Degree** (due June 15 or December 15, prior to the semester start of core nursing)
- ☐ **Occupational Therapy Assistant** (due 1st day of Activity Analysis and Applications/1st semester)
- ☐ **Pharmacy Technician** (due October 1)
- ☐ **Phlebotomy** (due the first day of Basic Skills)

Instructions:

1. This form must be filled out no sooner than 90 days before the date it is due.

2. The physical examination must be completed by a physician, nurse practitioner, or physician's assistant. You must print the Physical Examination page for the health provider to complete and sign. Scan the signed page and save it to submit or upload. The physical examination must be completed within the past year. If a physical has been completed within the past year, request that your provider complete the Physical Examination page. No substitute documentation is allowed for the Physical Examination page.

3. **Official** documentation is **required** for proof of history of infectious diseases or immunizations. Attach official health records documenting infectious diseases or immunizations to this form. You may be able to get your official immunization record from your healthcare provider or from a state immunization registry. Wisconsin Immunization Registry https://www.dhfswir.org/PR/logoff.do Other states may also have an immunization registry.

4. If you require accommodations as defined by the Americans with Disabilities Act, work directly with the WITC campus Accommodation Specialist and your instructor **prior to beginning coursework.**

5. Print and sign the release of information at the end of the form. Scan the signed form and save it to submit or upload.

6. Before submitting the health form to your instructor or uploading it to an online platform (CastleBranch or Student Passport System), **make a copy** of the completed form for your records.

WISCONSIN INDIANHEAD TECHNICAL COLLEGE
HEALTH SCIENCES PROGRAMS HEALTH FORM

Legal Name: Last | First | Middle

Date of Birth (MM/DD/YY) | Gender:

Current address

City | State | Zip Code

Primary phone number | Cell number

E-mail Address

In case of emergency contact: Name (First and Last) | Relationship to Person

Address | Telephone Number

MEDICATIONS and PAST MEDICAL HISTORY: ***TO BE COMPLETED BY THE STUDENT***

Describe Reaction: 1. Allergies (Medication or Agent): 2. Is an EpiPen prescribed? 3. Any reactions to latex/silicone?
Chronic diseases: Major illnesses, hospitalizations, operations, and/or injuries in the past year: Describe any back injuries or chronic back pain:
List all current medications: 1. Prescription 2. Non-prescription

PHYSICAL EXAMINATION: *to be completed by physician, nurse practitioner, or physician's assistant*

	NL	ABNL	Please describe any abnormalities. Use second sheet if necessary.
General	☐	☐	
Skin	☐	☐	
Head/Eyes/Ears/Nose/Mouth	☐	☐	
Neck and Thyroid	☐	☐	
Lungs/Chest	☐	☐	
Breasts	☐	☐	
Heart	☐	☐	
Abdomen	☐	☐	
Genitalia	☐	☐	
Back/Spine	☐	☐	
Extremities/Musculoskeletal	☐	☐	
Neurologic	☐	☐	
Emotional/Psychological	☐	☐	

A. Describe any abnormalities, limitations, and regularly-used medications that may have an impact on performance in a health agency setting.

B. Describe degree of control of any chronic conditions.

C. Are there any lifting restrictions for this student? If so, specify.

D. Are there any other restrictions for this student? If so, specify.

E. Is this student free from communicable diseases?

I have reviewed the medical history and immunization record and have examined the student. The information is accurate.

MD/NP/PA Signature _____ Date _____

MD/NP/PA (Print Name and credential) _____

Clinic Name: _____

INFECTIOUS DISEASES AND IMMUNIZATIONS

Required documentation for immunizations is based on published requirements from the Centers for Disease Control and Prevention (CDC) https://www.cdc.gov/

Official health records documenting these infectious diseases and/or immunizations *must accompany this form.*

You may be able to get your official immunization record from your healthcare provider or from a state immunization registry. The Wisconsin Immunization Registry (WIR) is a computerized internet database application that was developed to record and track immunization dates of Wisconsin's children and adults, providing assistance for keeping everyone on track for their recommended immunizations. Wisconsin Immunization Registry web address is: https://www.dhfswir.org/PR/logoff.do Other states may also have an immunization registry.

Disease	Required Documentation
Measles & Mumps	Lab evidence of immunity ***OR*** 2 doses of MMR after 1st birthday. The 2 doses must be at least 28 days apart.
Rubella	Lab evidence of immunity ***OR*** 1 dose of MMR after 1st birthday.
Tetanus, Diphtheria, & Pertussis	1 dose of Tdap Those who never received a Tdap vaccine should receive the vaccine regardless of time since the last Td vaccine. Tdap immunization lasts for 10 years. Td boosters should be given every 10 years after Tdap immunization. The CDC recommends that pregnant women receive a dose of Tdap during each pregnancy.
Varicella (Chickenpox)	Lab evidence of immunity ***OR*** 2 doses of Varicella vaccine after 1st birthday. The 2 doses must be at least 28 days apart.
Influenza	Annual influenza vaccine is **required** for ADN, HIT, MA, OTA, Phlebotomy, and Pharm Tech students. Annual influenza vaccine is **recommended** for DA students. Vaccination should occur before onset of influenza in the community.

Hepatitis B	Lab evidence of antibodies **OR** evidence of the start of the immunization series. • **ADN, DA, OTA, HIT, Phlebotomy, and Pharm Tech students** may begin clinicals after starting the Hepatitis B series. • **MA students** need to have had at least 2 of the immunizations before the start of practicum. Students should complete the Hepatitis B series. It is recommended by the CDC that health care providers receive a titer 1-2 months after completing the series.
Tuberculosis **The Tb skin test (Mantoux) comes as a 1-step or 2-step process:** • **1-step test** consists of an injection with a follow-up reading of the injection site within 48-72 hours. Results must report dates and mm of induration. • **2-step test** consists of an injection with a follow-up reading of the injection site within 48-72 hours, followed by a **second** injection and reading within 48-72 hours. The second injection is received within 1-3 weeks after the first injection is **read.** Results must report dates and mm of induration. **Where can I get my Tb skin test (Mantoux)?** This test may be available to WITC students through WITC Health Services during normal office hours. You can also receive this test at your local clinic.	**DA** students are required to have a 1-step Mantoux or IGRA blood test (QFT-GIT or T-SPOT). **ADN, HIT, MA, NA, OTA, Phlebotomy and Pharm Tech** students are required to have a 2-step Mantoux or IGRA blood test (QFT-GIT or T-SPOT). For students in programs over one year in length, a Tb skin test is required annually. If the Tb skin test or IGRA is positive, the following is required as part of the student health record: • Negative chest x-ray dated after positive Tb skin test conversion. • Written verification from a healthcare provider that the student is free of Tb symptoms and is not communicable. • Annual health symptom Tb questionnaire.
COVID-19	**Recommended** for all Health Sciences programs, except Nursing Assistant. Some clinical facilities **may require** students to receive the vaccination.

WISCONSIN INDIANHEAD TECHNICAL COLLEGE

Annual Tb Questionnaire
WITC Health Sciences Programs

Name _____

Date _____

Date of last Chest X-Ray (if positive Tb test or IGRA) _____

Do you currently have any of the following symptoms?	**Check Yes or No**	
1. Persistent cough (greater than 3 weeks duration)	☐ Yes	☐ No
2. Unexplained weight loss	☐ Yes	☐ No
3. Fever	☐ Yes	☐ No
4. Night sweats	☐ Yes	☐ No
5. Loss of appetite	☐ Yes	☐ No
6. Coughing up blood	☐ Yes	☐ No
7. Shortness of breath	☐ Yes	☐ No
8. Fatigue or weakness	☐ Yes	☐ No
9. Chest pain	☐ Yes	☐ No
10. Hoarseness	☐ Yes	☐ No

* Health Sciences students with a positive Tb skin test or IGRA must submit this Tb questionnaire annually.

I certify that all information is correct. I understand that it is my responsibility to report any changes in my health status to my WITC Program Director.

I authorize WITC to release my immunization record, which is attached to this form, to the clinical agency/agencies that require it for my participation in a clinical course.

Please Print Name _____

Student ID _____

Student Signature _____ Date_____