Southeast community college — STUDENT HEALTH STATEMENT

APPLICANT INFORMATION:

Name (PRINTED)_____ SCC ID# or SS# _____

Program_____

NOTE: THIS FORM WILL NOT BE ACCEPTED IF ANY PORTION IS LEFT BLANK.

If a vaccination is not indicated for you, immunity must be proven by a titer. If you choose to use Physicians Laboratory Services, Inc. for the titers, please attach a copy of your results. Please see attached form for explanation. **Day, month, and year MUST be indicated for all documentations.**

■ **Tdap** (Tetanus, Diphtheria, and Pertussis) Date: _____ (must be within last 10 years)

■ **Chicken Pox** (Varicella-Zoster) 2 doses Date: _____ and _____
Two doses required before submitting. CDC recommends a minimum of 28 days between doses. Indicating date of diagnosed disease is **NOT** acceptable.

OR Varicella-Zoster Virus Titer Date: _____ Findings:_____

■ **Mumps** (2 doses required before submitting or evidence of immunity) Date: _____ and _____

OR Mumps Titer Date: _____ Findings: _____

■ **Rubeola** (2 doses required before submitting or evidence of immunity) Date:_____ and _____

OR Rubeola Titer Date: _____ Findings: _____

■ **Rubella** (2 doses required before submitting or evidence of immunity) Date:_____ and _____

OR Rubella Titer Date:_____ Findings: _____

■ **Hepatitis B Vaccination** (Required for all health programs except Human Services) Three doses required: #1 to start, #2 one month later, and #3 five months after #2. If the series is in progress, first and second vaccination must be indicated and student must submit written proof of third dose as received.

Date: #1_____ #2_____ #3_____

If the series is interrupted, the CDC states you do NOT have to restart the series, just continue to complete the series.

OR Hepatitis B Antibody (Titer) Date:_____ Findings: _____

HEALTH CARE PROVIDER INFORMATION:

Health Care Provider signature and information required; title must also be indicated. (If it is determined that provider information is falsified in any way, the student will be dismissed from the program and will not be eligible for admission to any health program at SCC.)

Name (PRINTED): _____ Title:_____

Signature: _____

Clinic/Group Name:_____ Address: _____

City:_____ State:_____ Zip: _____

Phone Number: _____ Date Form Completed: _____

Retain a copy and send original/copy to the Campus you will be attending:

Southeast Community College–Beatrice
Attn: Admissions Office
4771 West Scott Road • Beatrice, NE 68310-7042
402-228-8214 or 1-800-233-5027

Southeast Community College–Lincoln
Attn: Health Sciences Division
8800 "O" Street • Lincoln, NE 68520-1299
402-437-2725 or 1-800-642-4075, ext. 2725

Distribution: White Copy – Health Sciences Division Yellow Copy – Student

Southeast community college

TUBERCULOSIS SKIN TEST

APPLICANT INFORMATION:

Name (PRINTED)_____ SCC ID# or SS# _____

Program_____

Initial Two-Step Tuberculosis skin test (within last 12 months) **Day, month and year must be indicated.**

TEST #1 Date:_____ Findings: _____

TEST #2 Date:_____ Findings: _____

(The second TB Test should be completed 7-21 days after the first TB reading.)

IF YOU HAVE A **POSITIVE TUBERCULOSIS SKIN TEST,** THE FOLLOWING MUST BE COMPLETED BY A HEALTH CARE PROVIDER:

T-Spot blood test: Date: _____ / _____ / _____

Result: _____ Negative _____ Indeterminate _____ Positive

OR

Interferon Gamma Release Assay (IGRA) blood test: Date: ___ / _____ / _____

Result: _____ Negative _____ Indeterminate _____ Positive

IF THE **BLOOD WORK SHOWS POSITIVE,** THE FOLLOWING MUST BE COMPLETED BY A HEALTH CARE PROVIDER:

Chest X-ray: Date: ___ / _____ / _____ _____ Normal _____ Abnormal
(Copy of the official X-ray/lab report must be attached.)

Treatment Completed: ___ No ___ Yes

Did you receive the BCG vaccination? ___ No _____ Yes
If yes, the student ***must*** provide the Health Science Division with documentation of a negative chest x-ray.

HEALTH CARE PROVIDER INFORMATION:

Physician, Physician Asst. or Registered Nurse signature and information required; title must also be indicated. (If it is determined that provider information is falsified in any way, the student will be dismissed from the program and will not be eligible for admission to any health program at SCC.)

Name
(PRINTED): _____ Signature: _____

Clinic/Group Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Date form completed: _____

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