Southeast community college
www.southeast.edu

AREA OFFICE: 301 SOUTH 68TH ST. PLACE, LINCOLN, NE 68510-2449, 402•323•3400
BEATRICE CAMPUS: 4771 W. SCOTT RD., BEATRICE, NE 68310-7042, 402•228•3468
LINCOLN CAMPUS: 8800 O ST., LINCOLN, NE 68520-1299, 402•471•3333
MILFORD CAMPUS: 600 STATE ST., MILFORD, NE 68405-8498, 402•761•2131

Dear Prospective Health Program Student,

RE: Important Information Regarding the Student Health Statement

One of the requirements for any health program is to submit a completed Student Health Statement documenting your immunizations, signed by a Health Care Provider. The clinical sites require that all students be fully immunized.

If you cannot provide a complete Student Health Statement due to lack of records, titers (blood draws), will need to be done. A titer cannot be done for the Tdap (Tetanus, Diphtheria and Pertussis) as this is a vaccination. If the Tdap is older than 10 years a booster is required. If any titer comes back as negative or equivocal further immunizations are required.

Physician's Laboratory Services, Inc. can perform titers for students at a discounted rate (please see the attached form). Students under the age of 19 must have a parental/guardian signature.

You must submit the results of your immunizations and/or titers to the Health Sciences Division office located in room B-4 on the 8800 O campus. However, if you are using Physician's Laboratory Services, Inc., a copy of the results will be submitted directly to the SCC campus. You will want to keep a copy of the titer results and/or Student Health Statement for your records as you may be required to present them to the clinical sites.

The Two-Step Tuberculosis Skin Test will be required within 12 months of attending clinical. Additional information for this requirement will be provided by your program.

If any portion of the Student Health Statement is left incomplete, further documentation signed by a Health Care Provider must be included. **The Student Health Statement requires your full name, Student ID, and name of the health sciences program and WILL NOT be accepted if it is not documented.** If you have questions regarding the Student Health Statement or using Physician's Laboratory Services, please contact the Health Science Division at 402-437-2725 or 402-437-2726.

Please provide these documents as soon as possible to ensure your ability to start the program.

Sincerely,

Health Science Division

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

PHYSICIANS LABORATORY SERVICES

STUDENT IMMUNIZATION PANEL

Physicians Laboratory Services, Inc. is offering a Student Immunization Panel, which includes the following tests:

- Varicella Zoster IgG
- Mumps IgG
- Rubeola IgG
- Rubella IgG
- Hepatitis Surface Antibody

This test will be performed for students at a discounted rate. To have this panel performed you must go to Physicians Laboratory to be drawn. Their locations are listed below.

Physicians Laboratory Services (Omaha)
4840 F St
Omaha, NE 68117
(402)731-4145

Physicians Laboratory Services (Lincoln)
7441 O St, Suite 100
Lincoln, NE 68510
(402)488-7710

Students must pay by cash or check at the time of service. A copy of the results will be sent to Southeast Community College and to the student's home address. You must read and complete the following:

Note to Recipient of Records: The patient's medical record is privileged information which is protected by various State and Federal laws. Such information may not be further disclosed to other persons without a separate written authorization from the patient.

(1) I, _____ born _____
(Patient's Name) (Date of Birth)

_____
(Street Address) (City) (State) (Zip Code)

I authorize Physicians Laboratory Services, Inc to release to the party listed in section 2 my Laboratory test results for the Student Immunization panel.

(2) My medical record may be inspected by and/or copies may be released to:
Southeast Community College
Health Science Division, Rm B4
8800 O St
Lincoln, NE 68520
Fax: 402-437-2592

_____ _____
(Patient's Signature) (Date)

If the patient is a minor or subject to guardianship, I have signed my name below on behalf of the patient and myself:

_____ _____
(Patient's Legal Guardian's or Agent's Signature) (Date)

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:** __________

Distribution: White Copy – Program Chair Yellow Copy – Student A0538(5/17)