HEALTH REQUIREMENTS

IMMUNIZATIONS

Official documentation is required. This can be a record signed by a health care provider or an official immunization record. Phrases such as “in childhood” are not acceptable. The date of the immunization must be noted.

Mantoux TB test or Quantiferon Lab Results

The TB skin test must be read in 48-72 hours by a health care professional. The person interpreting the test must indicate results as positive or negative and sign their name and professional title in the space provided in the section for the TB test. Do not have this done on a Thursday unless you are sure it can be read on Saturday.

If you are having this done at the Health Department, try to have the results before seeing your physician for a physical. Students who are in a program longer than 1 year must have the Mantoux test repeated on a yearly basis. A baseline x-ray is required if the Mantoux test is positive. If there is a previous history of positive skin test, an x-ray done within the 12 months previous to the clinical start date will be required. Once an x-ray that is negative for active disease is submitted, it is not required yearly as long as the person is without symptoms of TB. The lack of symptoms must be documented by a health care fractioned on a yearly basis and this documentation submitted to Health Records.

Tetanus

It is not required at this time, but highly recommended for students who have patient contact. If you elect not receive the vaccine, then the waiver needs to be signed and dated.

If you choose to be vaccinated and documentation is provided, immunization must be within 10 years. If it has been 8-9 years, renewal is recommended.

Hepatitis B

It is not required at this time, but highly recommended for students who have patient contact and/or work with body fluids. Check with your insurance carrier to see if it is a covered service. It is required that students read the information provided about HBV and complete the Acknowledgement and Release Form. The dates of the 3 vaccines should be reported to the health records nurse with verification as they are received.
Medical Restrictions

Any student who is or becomes pregnant, or has any type of medical restriction during the course of their clinical experience MUST obtain a waiver from their physician and return to Health Records before entry into the clinical area.

Please Keep copies of everything submitted to Gateway Technical College!!
If you have any questions regarding your health records, please call:

For Racine/Kenosha Programs:
Gateway Technical College
Attn: Stacey Casey, RN
Health Records
3520 30th Avenue
Kenosha, WI 53144-1690
(262) 564-2734
Fax: (262) 564-2299
caseys@gtc.edu

For Elkhorn/Burlington Programs:
Gateway Technical College
Attn: Marianne Douglas, RN
Health Records
496 McCanna Pkwy.
Burlington, WI 53105-3622
(262) 767-5728
Fax: (262) 767-5729
douglasm@gtc.edu
HEALTH CAREER PROGRAMS

PROGRAM: ________________________________________________________________

STUDENT NAME: ___________________________________________________________

ADDRESS: __________________________________________________________________

CITY: ___________________________ STATE: _________________________________

PHONE: ___________________ DATE OF BIRTH: ______________________________

STUDENT ID: ____________________________

GATEWAY E-MAIL ADDRESS: ____________________________________________

Were you ever in another Health Occupations Program? Yes _____ No _____

What Program __________________________________________________________

What Campus ___________________________ Date in Program _________________

I understand that the information provided in this Health Care Packet may be shared with Gateway Technical College's associated clinical and field sites and consent to its release. I understand that Gateway cannot guarantee allergen-free clinical or field sites and, if I have an allergy or sensitivity to a particular allergen, it is my responsibility to mitigate potential reactions through appropriate means. I further affirm that the information contained within this form is true and accurate.

STUDENT/GUARDIAN SIGNATURE: ________________________________________

Gateway Technical College
Attn: Health Records
3520 30th Avenue
Kenosha, WI 53144-1690
(262) 564-2734  Fax (262)564-2299
Eschenbauch@gtc.edu
Caseys@gtc.edu

Gateway Technical College
Attn: Health Records
496 McCanna Pkwy.
Burlington, WI 53105-3622
(262) 767-5728 Fax (262)767-5729
Douglasm @gtc.edu

Equal Opportunity/Access Education/Employer
Igualdad De Oportunidades
TUBERCULIN TEST
(UPDATED ANNUALLY THROUGHOUT THE PROGRAM)

STUDENT NAME: ____________________________ STUDENT ID ____________________

PROGRAM: ________________________________________________________________

MANTOUX TUBERCULIN SKIN TEST
Must be within 6 months of date of program entry.
Must with within 90 days of program entry for Nursing Assistant.

Date Given: ____________________________ Date Read: ____________________________

Results: ________________________________________________________________

-OR-

QUANTIFERON (attach copy of lab results)

Date Given: ____________________________ Lab Results: ____________________________

CHEST X-RAY – Only if Test is Positive
Attach a copy of report.
Previously positive reactors must have x-ray within 1 year of entry into program.

Results: ________________________________________________________________

TREATMENT

Treatment recommendations for abnormal findings: ____________________________

Health Care Provider Signature: ____________________________ Date ______________

Health Care Provider Printed Name: __________________________________________

Health Care Provider Contact Information:

Gateway Technical College
Attn: Health Records
3520 30th Avenue
Kenosha, WI 53144-1690
(262) 564-2734 Fax (262)564-2299
Eschenbauch@gte.edu
Caseys@gte.edu

Gateway Technical College
Attn: Health Records
496 McCanna Pkwy.
Burlington, WI 53105-3622
(262) 767-5728 Fax (262)767-5729
Douglasm@gte.edu

Equal Opportunity/Access Education/Employer
Igualdad De Oportunidades
TETANUS IMMUNIZATION FORM

STUDENT NAME: ___________________________ STUDENT ID __________________

PROGRAM: ____________________________________________________________

TETANUS

Date Received: __________________________________________________________

-OR-

I am aware of my responsibilities and elect not to receive the vaccine at this time.

Student Signature: __________________________________ Date: ________________

Health Care Provider Signature: __________________________________________ Date __________________

Health Care Provider Printed Name: _________________________________________

Health Care Provider Contact Information: __________________________________

Gateway Technical College
Attn: Health Records
3520 30th Avenue
Kenosha, WI 53144-1690
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Equal Opportunity/Access Education/Employer
Igualdad De Oportunidades
HEPATITIS B AND THE HEPATITIS B VACCINE INFORMATION

Hepatitis B is a liver disease caused by the Hepatitis virus. Anyone can get Hepatitis B, but those who are at greatest risk include:

- Certain household contacts of an infected person
- Certain health care workers who have contact with infected blood
- Persons who work in centers for persons with developmental disabilities
- Drug users who share needles
- Homosexuals, especially those with multiple sex partners
- People who have been incarcerated and individuals who work with them

Hepatitis B virus can be found in the blood, and to a lesser degree in saliva, semen and other bodily fluids of an infected person. It is spread by direct contact with infected body fluids, usually by a needle stick injury, sharing needles or sexual contact. Hepatitis B is not spread by casual contact or by respiratory droplets.

The symptoms may appear 2 to 6 months after exposure, but usually within 3 months. The symptoms of Hepatitis B include fatigue, poor appetite, fever, vomiting, and occasionally joint pain or rash. Urine may become darker in color and a yellowing of the skin and whites of the eyes may appear.

Some individuals may experience few or no symptoms. Chronic carriers are at increased risk of cirrhosis of the liver and liver cancer.

The Hepatitis B virus can be found in the blood and other bodily fluids several weeks before symptoms appear and generally persist for several months afterward. About 10 percent of infected people may become long-term carriers of the virus, and may remain contagious, even though they do not present any symptoms whatsoever.

There is no specific medical treatment or antibiotic that can be used to treat a person once symptoms appear. Usually bed rest is required.

**In many cases, receiving the Hepatitis B vaccine can best prevent Hepatitis B.** The Hepatitis B vaccine is administered intramuscularly in a series of three injections given at set intervals; at the first visit, one month later and then 6 months after the first injection. To obtain the highest degree of effectiveness, the series of three injections should be completed.

Health care providers will determine if an individual is a candidate for the vaccine.
ACKNOWLEDGEMENT AND RELEASE FORM

HEPATITIS B

I hereby acknowledge that I have received and reviewed the information provided regarding Hepatitis B and the Hepatitis B vaccine. I understand that I assume the risk of infection from communicable diseases, including Hepatitis B, from my clinical experience.

I understand that receiving the Hepatitis B vaccine is highly recommended but not required at this time, except for certain designated Program clinicals. I also understand that should I elect to receive the Hepatitis B vaccine, I will obtain it from my own health care provider and it will be my responsibility to pay the cost for the series of three injections. According to Gateway Policy H-185, “A student, upon signing and informal release, may voluntarily waive the Hepatitis B vaccination. However, the college cannot guarantee that the said student will be admitted to clinical sites if he/she elects to waive the Hepatitis B vaccination.”

I understand that all medical bills associated with injuries, illnesses or contracting a communicable disease during my clinical education are my responsibility; neither Gateway Technical College nor the affiliating clinical agencies have an obligation to pay my medical expenses.

Please initial ONE of the following:

_____ I have read the preceding statements regarding Hepatitis B and the Hepatitis B vaccine. I am aware of my responsibilities and I elect NOT to receive the vaccine.

_____ I have received the Hepatitis B Vaccine. List dates of vaccinations below.

   Hepatitis #1 _______   Hepatitis #2 _______   Hepatitis #3 _______

Hepatitis Titer (date completed and results): ____________________________

_________________________________________  Date

Health Care Provider Signature: ________________________________

Health Care Provider Printed Name: ________________________________

Health Care Provider Contact Information: __________________________

_________________________________________  ID #

If student is a minor (under 18 years of age) signature of parent/legal guardian is required.

Parent/Legal Guardian Signature ________________________________  Date ________________