TALLAHASSEE COMMUNITY COLLEGE
NURSING ASSISTANT HEALTH ASSESSMENT FORM

Name (print clearly):_____
First M.I. Last

INSTRUCTIONS: The following information must be completed by the attending physician or staff members *only*.

Tuberculosis (TB Skin Test) PPD
Required annually. If results are positive a chest X-ray is required. Please attach x-ray results, if any. *Note: A 2 step PPD may be required if no documentation of annual PPD's.*

Skin Test		
Date Administered	Date Read	Results

Chest X-Ray	
Date	Attach Results

Seasonal Flu:
Required for ***each*** season by the date requested.

Date Administered

Varicella (Chicken Pox)
Must have positive titer or proof of two Varicella immunizations.

Titer - IGG	
Date	Attach Results

OR

Immunizations	
Date of 1st	Date of 2nd

MMR (Measles, Mumps, Rubella)
Student must have proof of 2 MMR vaccines or a positive titer result. If not immune then patient must receive immunizations one month apart to complete series.

Immunizations	
Date of 1st	Date of 2nd

OR

Titers					
Measles - IGG		Mumps - IGG		Rubella - IGG	
Date:		Date:		Date:	
Attach Results		Attach Results		Attach Results	

Hepatitis B Series
Strongly recommended, but not required. A signed declination waiver will be required from those who elect not to receive the vaccination. The waiver is available at the 3rd floor reception area.

Immunizations		
Date of 1st	Date of 2nd	Date of 3rd

OR

Titer - Surface Ab	
Date	Attach Results

The above information is true and accurate to the best of my knowledge. The release of this information is authorized by the above named individual to Tallahassee Community College's Health Care Professions Division and its clinical affiliates.

Signature _____ Title _____ Date _____

Printed Name _____ Name of Medical Facility _____ Phone Number _____