Health Record

To be completed by all Dental Assistant and Medical Assistant students only.

STUDENT INFORMATION

Name _____ Social Security Number XXX – XX – _____

Program _____

HEPATITIS B VACCINE STATUS

☐ I have previously received the complete Hepatitis B vaccine series on or about these dates.
_____/_____/_____ _____/_____/_____ _____/_____/_____

☐ I received the Hepatitis B vaccine series about 7 years ago, now I plan to get the titer at my own expense. I understand that until I get the titer, I am still at risk of acquiring the Hepatitis B virus (HBV) infection.

☐ I plan to get the Hepatitis B vaccine series. I understand the risks and benefits of the Hepatitis B vaccine. I further understand that I am responsible for payment of injections. I understand that until my vaccine series is complete, I am still at risk of acquiring the Hepatitis B virus (HBV) infection.

☐ I have read and understand the following statement; and I do not plan to get the Hepatitis B vaccine at this time.

"I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring the Hepatitis B virus (HBV) infection. However, I do not plan to get the Hepatitis B vaccination at this time. I understand that by not being vaccinated, I continue to be at risk of acquiring Hepatitis B, a serious disease."

TB (Tuberculosis Screening) / MMR (Measles-Mumps-Rubella)

TB (Tuberculosis) Date of last TB skin test: _____/_____/_____ Results: ☐ Positive ☐ Negative ☐ Never Taken

If positive: Date of last chest film: _____/_____/_____ ☐ Attach a copy of interpretation

MMR (Measles – Mumps – Rubella) Date: _____/_____/_____ Positive Titer Date: _____/_____/_____

Communicable Diseases

❑ No- I do not have any communicable diseases (i.e. MRSA, flu, etc) that could affect the health and safety of others.

❑ Yes- I do suspect, have been diagnosed, or have tested positive for a communicable disease.

If yes: please describe: _____

Acknowledgement

The information here is accurate and complete to the best of my knowledge. I also understand that if I acquire a communicable disease while in school, I am to report it to a school official. Depending on disease and diagnosis, I may be asked to leave school for the health and safety of the students, staff, and faculty until released by a physician.

_____	_____	_____/_____/_____
Student Name (please print)	**Student Signature**	**Date**
_____	_____	_____/_____/_____
College Official (please print)	**College Official Signature**	**Date**

Revised July 11, 2019