Health Science Programs

Medical Evaluation Physical and Immunization Review *(MEPIR)*

____

(Health Science Program Name)

____

(Print Your Name)

***Disclaimer:** The health history and physical of any student **IS NOT** used as criteria for acceptance into any Health Sciences Program.

Instructions for Students in Preparation for the MEPIR Appointment:

- **Complete the highlighted fields.**
- **Bring to your appointment:**
  - Documentation of any immunizations, immunity blood work, tuberculosis testing, tuberculosis treatment (done both in/out of Iowa).
  - A copy of your "Program-Specific Physical Eligibility Requirements Form"
- **NOTE: Failure to provide the requested documentation may result in a delay of the clinic's ability to complete your determination of eligibility.**

Do you have a known communicable disease or other health condition that poses a threat to the health, safety, or well-being of others?

☐ ***Yes** (if yes, describe:____)*

☐ ***No***

Student Signature: ____ ***Date:*** ________________

HAWKEYE COMMUNITY COLLEGE

Name: ______________________________

Date of Birth: _____ /_____ /_____

Today's Date: _____ /_____ /_____

Tuberculosis Screening & Testing

TB Screening, Testing, and Treatment guidelines of Hawkeye Community College's Health Science students are based on Chapter 59 Iowa Code of Inspections and Appeals (2018), the National TB Controllers Association, and the CDC TB Guidelines of HCP (2019) (https://www.cdc.gov/tb/topic/testing/healthcareworkers.htm, https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?s_cid=mm6819a3_w#B1_down)

Hosting healthcare facilities may have practice standards set forth by their institution that vary from the references listed above and may request additional testing of student HCPs for clinical entry into these facilities.

ALL Health Science Students will need **Baseline TB Screening and Testing** prior to the start of clinical experiences. This consists of the following: **(Part 1)** Baseline Individual TB Risk Assessment, **(Part 2)** TB Symptom Evaluation, and **(Part 3)** Documentation of negative testing using the 2-Step Tuberculin Skin Test (TST) procedure or a single blood test (Serum TB IGRA) performed once; ever. Results may be submitted from the past or new testing initiated.

- **2-Step TST Testing procedure:** 1) TST #1 placement 2) TST #1 Read 48-72 hours later 3) TST #2 placement 4) TST #2 read 48-72 hours later
    - (TST #1 Read & TST #2 Placement are recommended to be 1-3 weeks separated, but shall not be > 12 months apart.)
- If you have a history of a **previous positive test, previous diagnosis of tuberculosis and/or treatment** your medical record should be presented to support this or repeat testing will be ordered.
- **Annual TB Screening, Testing, and Education:** Annual TB testing of health care personnel (HCP) is **not** recommended unless there is a known exposure or ongoing transmission at a healthcare facility. **Despite this**, it is still **required by many hosting clinical sites that student HCPs be TB tested annually in order to partake in clinical experiences within their facilities.** Student HCPs with a previous positive test may discuss options with the SHC on a case to case basis as repeat testing will always return positive.

Baseline Screening "Part 1": Individual TB Risk Assessment

Have you lived in a country with a high TB rate? (Check "Yes" if you were BORN IN or SPENT LONGER THAN 30 days in any country other than the United States, Canada, Australia, New Zealand, and those in Northern Europe or Western Europe.)

________No _______Yes (Country-______________________________)

Are you considered "*immunosuppressed*" (to have a weakened immune system) or scheduled to take medications for immunosuppression? (Conditions such as human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication).

_______No _______Yes (Reason-______________________________)

Have you been in close contact with a person with infectious "active" TB disease?

_______No _______Yes (When?______________________________)

Baseline Screening "Part 2": TB Symptom Evaluation

Are you experiencing any of the following symptoms of tuberculosis?
A bad cough lasting 3 weeks or longer, pain in the chest, coughing up blood, unexplained weakness or fatigue, unexplained weight loss, drenching night sweats, unexplained fevers?

_______No _______Yes (Details-______________________________)

Have you EVER had a POSITIVE test for tuberculosis?
_______No _______Yes (When:__________, Where:______________________________)

"Part 3": Record of Testing *(completed by qualified HCP)*

Provider Recommendations for Testing: ___ **2-Step TST** ___ **Serum TB Testing** ___ **Annual TST** ___ **Other (details:**______________________________

	Date Placed	Time	R/L	Signature of Provider	Date Read	Time	mm	+/-	Signature of Provider
TST #1									
TST #2									

Serum TB Test: _______________ Result: _______________ Chest X-Ray: _______________ Result: _______________ Referral:_______________

Additional Notes:______________________________

HAWKEYE COMMUNITY COLLEGE

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Today's Date: ______ /______ /______

Immunization Review

****To be completed by a Physician, Nurse Practitioner, or Physician Assistant*****

Vaccine	Vaccine or Titer Dates or Attached	Advisory Committee on Immunization Practice (ACIP) Adult HealthCare Workers Immunization Recommendations.
Hepatitis B: Hepatitis B Vaccines (a series with 2 or 3 vaccines) OR a positive Hepatitis B Surface Antibody Titer alone will meet this requirement.	☐ Hep B #1____________ ☐ Hep B #2____________ ☐ Hep B #3____________ **OR** ☐ Hep B Titer:_________	☐ **Vaccination UTD and ACIP Healthcare Worker recommendation** is **MET.** *(HCP: Clinical entry criteria is met)* ☐ **Series has been Initiated, NOT Completed.** Additional vaccinations in this series are indicated to meet the ACIP Healthcare Worker recommendations. *(HCP: Clinical entry criteria is met)* ☐ **NO Documents** supporting vaccination or immunity, therefore ACIP Healthcare Worker recommendation is **NOT MET**.
MMR (Measles, Mumps, Rubella): Any combination of 2 individual/combined vaccines for each disease, at least 28 days between doses OR lab report(s) indicating positive titers for MMR (all three diseases)	☐ MMR #1____________ ☐ MMR #2____________ **OR** ☐ Mumps Titer:__________ ☐ Measles Titer:_________ ☐ Rubella Titer:__________	☐ **Vaccination UTD and ACIP Healthcare Worker recommendation** is **MET.** *(HCP: Clinical entry criteria is met)* ☐ **Series has been Initiated, NOT Completed.** Additional vaccinations in this series are indicated to meet the ACIP Healthcare Worker recommendations. *(HCP: Clinical entry criteria is met)* ☐ **NO Documents** supporting vaccination or immunity, therefore ACIP Healthcare Worker recommendation is **NOT MET**.
Varicella (Chicken Pox): 2 Varicella vaccines, at least 28 days apart, lab report indicating positive titer, or medical documentation by a HCP of a diagnosis of shingles or chickenpox.	☐ Varicella #1____________ ☐ Varicella #2____________ **OR** ☐ Varicella Titer:_________	☐ **Vaccination UTD and ACIP Healthcare Worker recommendation** is **MET.** *(HCP: Clinical entry criteria is met)* ☐ **Series has been Initiated, NOT Completed.** Additional vaccinations in this series are indicated to meet the ACIP Healthcare Worker recommendations. *(HCP: Clinical entry criteria is met)* ☐ **NO Documents** supporting vaccination or immunity, therefore ACIP Healthcare Worker recommendation is **NOT MET**.
Tdap (Tetanus, Diphtheria, Pertussis): Tdap once and updated with a TD/Tdap every 10 years.	☐ Tdapx1:____________ ☐ Booster:___________	☐ **Vaccination UTD and ACIP Healthcare Worker recommendation** is **MET.** *(HCP: Clinical entry criteria is met)* ☐ **Series has been Initiated, NOT Completed.** Additional vaccinations in this series are indicated to meet the ACIP Healthcare Worker recommendations. *(HCP: Clinical entry criteria is met)* ☐ **NO Documents** supporting vaccination, therefore ACIP Healthcare Worker recommendation is **NOT MET**.

COVID-19 (current CDC/ACIP recommendation)	☐ ACIP Healthcare Worker recommendation is met. ☐ ACIP Healthcare Worker recommendation is NOT MET. ☐ ____
Influenza *(current CDC/ACIP recommendation; Seasonal for August - March)*	☐ ACIP Healthcare Worker recommendation is met. ☐ ACIP Healthcare Worker recommendation is NOT MET ☐ *Out of Season for this Vaccine (August-March)*

HAWKEYE COMMUNITY COLLEGE

Name: ______________________________
Date of Birth: ______ /______ /______
Today's Date: ______ /______ /______

Health Science Program Eligibility Form

*****To be completed by a Physician, Nurse Practitioner, or Physician Assistant*****

Overall Health Status:

I have met with the patient, reviewed their **Program-Specific Physical Eligibility Requirements, Tuberculosis Risk & Symptom Evaluation, and Immunization Review** forms.

Based on these findings, on this date, I find this patient to be:

Conclusion:

- ☐ Medically eligible for program participation without restriction
- ☐ Medically eligible for program participation with the **following recommendations:**
  ____
  ____
- ☐ Not Medically Eligible: ____

Commentary:____

____

Clinic Name *(Stamp)*:	
Provider Signature:	**Date of Review:**

Please provide documentation of tuberculosis testing, historical immunizations, titers of immunization, and/or record of vaccinations administered regarding this review to the patient for their program submission.