All MATC Health Science students are required to complete and upload health requirements prior to petitioning for courses which contain a clinical component. MATC School of Health Sciences has partnered with Certified Background.com to provide health record tracking for all MATC Health Sciences students. The cost of the health record tracking is the responsibility of the student.

Use the steps below to complete the Certified Background (CB) electronic health record tracking process.

- Visit CertifiedBackground.com website: www.certifiedbackground.com
- Look for the place order box on the homepage.
- Enter the package code MF49im (package code is specific to the Surgical Technology program)
- Follow the directions to setup your CB account

* The cost of the health examination and immunizations are your responsibility. You may be able to obtain health care services at your local Health Department or you may call 1-866-211-3380 for a list of clinics in your area.

* If a student is accepted into core technical courses via petitioning, he or she will receive instructions for completing mandatory drug testing. The cost for the drug testing is the responsibility of the student.

- (1) Physical Examination
- (2) Measles, Mumps and Rubella (MMR) Vaccination
- (3) Varicella (Chicken Pox) Vaccination
- (4) Tuberculosis Test
- (5) Tetanus Vaccination
- (6) Hepatitis B Vaccination
- (7) Handbook Acknowledgement
- (8) Liability Release
- (9) CPR Certification
- (10) Essential Functions Form
- (11) Ocular History and Medical Laser Surveillance (Eye Exam)
- (12) Influenza (Flu) Vaccination
Student Information

(Print Name and Address)
NAME: ______________________________________ BIRTHDATE: ______/_____/_____
ADDRESS: __________________________________ CITY/STATE __________ ZIP CODE __________
Program Name: __________________________________ Telephone #: ______________________
Cell Phone #: ______________________ E-Mail Address: ________________________________
Student ID #: ______________________

IMPORTANT:
I give my permission to release information on the health requirements to the professional college and clinical
affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.

______________________________________________________
Student Signature

Physical Examination
(1)

VERIFICATION OF STUDENTS GOOD HEALTH
(Only Physician, Physician Assistant, or Nurse Practitioner, to Complete the Following):

I have examined _____________________________________________________ and certify that she/he is in
good physical and mental health. Student’s Name

On letterhead stationery, please list any physical limitations or other disabilities which would limit this individual’s
capacity to perform the essential functions of this profession. (See attached)

______________________________________________________________
Physicians, Physician Assistant or Nurse Practitioner SIGNATURE & Medical Title Date

Print Professional’s Name: ________________________________ Office Telephone # ______________________

Address: __________________________ City: ____________ State: __________ Zip: _____________

A full exam is on file at: __________________________________________

**I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is
deemed necessary for the benefit and/or safety of myself and others.

Student Name: ___________________ Signature: ___________________ ID #: ___________________

MATC is an Affirmative Action/Equal Opportunity Institution and complies with all requirements of the Americans with Disabilities Act
Proof of at least two MMR’s at least 30 days apart or blood test evidence of rubella and measles immunity. A copy of the titer lab results must be attached if a blood test is performed.

1) MMR
   Date: _______________  Authorized Signature & Medical Title: __________________________

2) MMR
   Date: _______________  Authorized Signature & Medical Title: __________________________

   OR

   Rubella Titer __________ Date: __________  Authorized Signature & Medical Title: __________________________

   AND

   Rubeola Titer __________ Date: __________  Authorized Signature & Medical Title: __________________________

*I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.

Student Name: _________________________ Signature: ______________________ ID #: __________________
CHICKEN POX
Must have documentation of Health Care Provider Diagnosed Chicken Pox. If no documentation is available, must have positive blood titer test or documentation of 2 shot vaccinations at least 30 days apart. A copy of the titer lab results must be attached if a blood test is performed.

RESULTS
Has this patient had?

<table>
<thead>
<tr>
<th>Chicken Pox</th>
<th>Yes</th>
<th>No</th>
<th>Date</th>
<th>Authorized Signature &amp; Medical Title</th>
</tr>
</thead>
</table>

OR

<table>
<thead>
<tr>
<th>Varicella Vaccine #1</th>
<th>Date</th>
<th>Authorized Signature &amp; Medical Title</th>
</tr>
</thead>
</table>

30 Days later

<table>
<thead>
<tr>
<th>#2</th>
<th>Date</th>
<th>Authorized Signature &amp; Medical Title</th>
</tr>
</thead>
</table>

OR

<table>
<thead>
<tr>
<th>Varicella Titer</th>
<th>Date</th>
<th>Results</th>
<th>Authorized Signature &amp; Medical Title</th>
</tr>
</thead>
</table>

**I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.**

Student Name: _________________________ Signature: _________________________ ID #: _________________________
TWO STEP MANTOUX TUBERCULIN SKIN TEST:

Documentation of a Two Step test must be submitted. Skin tests are good for 1 year. If the 2-step is more than a year old, attach documentation of the past 2-step dates, along with a current annual update.

PROCEDURE:

**Step 1:**
A Mantoux Tuberculin Skin Test of 0.1 (STU) PPD is administered under the skin on the forearm. A health care professional must read the results within 48-72 hours. If negative perform step 2. If positive, must follow-up with a chest x-ray.

**Step 2:**
Repeat the test within 7 to 30 days after the application of the first test using the same strength of PPD. A health professional must read the results within 48-72 hours. If positive, must follow-up with a chest x-ray.

**QUANTIFERON – TB GOLD TEST:**

The TB Gold blood draw may be performed in place of skin tests. TB gold blood draws are good for one year and a copy of the lab report must be attached to the health packet.

**REPORTING RESULTS** (2 Step or Chest X-Ray or TB Gold)

1. **Step 1 Results**

<table>
<thead>
<tr>
<th>Date Administered</th>
<th>Date Read</th>
<th>Results</th>
<th>Authorized Signature &amp; Medical Title</th>
</tr>
</thead>
</table>

2. **Step 2 Results**

<table>
<thead>
<tr>
<th>Date Administered</th>
<th>Date Read</th>
<th>Results</th>
<th>Authorized Signature &amp; Medical Title</th>
</tr>
</thead>
</table>

**Chest X-Ray (if required)**

<table>
<thead>
<tr>
<th>Date Administered</th>
<th>Date Read</th>
<th>Results</th>
<th>Authorized Signature &amp; Medical Title</th>
</tr>
</thead>
</table>

**TB Gold Titer (if required)**

<table>
<thead>
<tr>
<th>Collection Date</th>
<th>Date Read</th>
<th>Results</th>
<th>Authorized Signature &amp; Medical Title</th>
</tr>
</thead>
</table>

**Annual Update**

<table>
<thead>
<tr>
<th>Date Administered</th>
<th>Date Read</th>
<th>Results</th>
<th>Authorized Signature &amp; Medical Title</th>
</tr>
</thead>
</table>

**I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.**

**Student Name:** ___________________________ **Signature** ___________________________ **ID #:** ___________________________

MATC is an Affirmative Action/Equal Opportunity Institution and complies with all requirements of the Americans with Disabilities Act
PROOF OF TETANUS VACCINATION: (Within the last 10 years)

____________________                               __________________________________________

Date                          Authorized Signature & Medical Title

**I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others

Student Name:________________________Signature:__________________________ID #:_________________
Please read thoroughly and check the appropriate box.

☐ As a student, I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been advised to be vaccinated with Hepatitis B vaccine. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can pursue the vaccination series. I hereby release Milwaukee Area Technical College, its Board Members, and personnel, and any clinical facility at which I train from any liability for any consequences to me or any claims arising out of or related to my decision to be or not to be vaccinated. I hereby agree to indemnify all of the above persons and organizations for any and all claims, including the attorneys' fees and costs, which may be brought against any one of them by anyone claiming to have been injured as a result of any injury which may occur as a result of my decision.

OR

☐ I do not wish to decline the Hepatitis B vaccine. I am currently in the process/or have completed the series. Understand that full immunity requires three doses of vaccine over a nine-month period.

______________________________________________
Signature of Student                               Student ID#

__________________________________________________________
Print Name

IF HBV given:
1st Dose Date: ____________
Authorized Medical Signature

2nd Dose Date: ____________
Authorized Medical Signature

3rd Dose Date: ____________
Authorized Medical Signature

**I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.

Student Name: _________________________Signature: ___________________________ ID #: ____________________
School of Health Sciences
Student Handbook Signature Page

I acknowledge that I am responsible for the contents of the current School of Health Sciences Student Handbook located on the MATC website at:

http://www.matc.edu/student/Admissions/upload/Health_Sciences_handbook.pdf

I further agree to abide by the terms and conditions found in the contents of the current School of Health Sciences Student Handbook.

Student Signature: ________________________________________________

Student Name: (Please print) _______________________________________

Student MATC ID Number: _______________________________________

Signature Date: ____________________________

**I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.

Student Name: _______________________ Signature ______________________ ID #: ________________
In consideration of its educational value and individual benefits, students will be enrolling in courses that require him/her to assume the duties of his/her field of study. Students must follow standard precautions established by his/her program and clinical/field placement site. Depending on the program, students understand that there are a number of risks/dangers that may be encountered. The student may come in contact with sharp, contaminated medical instruments, contagious diseases, infectious blood and/or body fluids, electrical instruments, electronic devices or other risks associated with patient care/non-patient care and the particular site. Transportation and safety to, from and during the clinical experience is the responsibility of the student. Be aware that precautions must be taken when walking to and from parking lots at various times of the day and night.

The student agrees and understands that he/she is responsible for his/her health and medical bills for sickness and injury. Any injuries that a student suffers while participating in the program will not be covered by the Wisconsin Worker’s Compensation Act. Therefore, it is critical that every participating student obtain health insurance coverage. The student agrees to the fullest extent permitted by law, to indemnify, defend and hold harmless: MATC, its Board, agents, officers and employees from and against all loss and expense including costs and attorney’s fees by reason of liability for damages including suits, in law or in equity, caused by any wrongful, intentional or negligent act or omission of the student which may arise out of or in connection with the activities covered by the program.

In signing this release, the student acknowledges and represents that he/she has read and understands the above. The student further acknowledges that he/she is at least eighteen (18) years of age and fully competent to sign this agreement and release. Students under eighteen (18) years of age are required to have the signature of a parent or guardian on this agreement and release.

Student Name: _________________________Signature: _________________________ ID #: ________________

Parent/Legal Guardian Relationship to Student
(Signature required if student is under age 18)

**I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.
CPR Verification: American Heart Association 2 year Healthcare Provider level only.

Sign your CPR card and upload a copy of the FRONT and BACK of the card to CertifiedBackground.com.
ADA AND ESSENTIAL FUNCTIONS
The Americans with Disabilities Act (ADA) of 1990 (42 USC & 12101, et seq.) and the ADA Amendment Act of 2008, and Section 504 of the Rehabilitation Act of 1973 (29 USC & 794) prohibits discrimination of persons because of her or his disability. In keeping with these laws, Milwaukee Area Technical College makes every effort to ensure a quality education for students. To aid in student success, it is important to inform students of the essential functions demanded by a particular occupation. The purpose of this document is to ensure students acknowledge that they have been provided information on the essential functions required for their chosen program. To meet the Essential Functions, information on accommodations is available upon request of the applicant. Please visit the MATC Student Accommodation Services Department.

INSTRUCTIONS
☐ Click on YOUR program link below.
☐ Read the essential functions required for success in your program.
☐ If you have read and understood the essential functions for your program, sign and date this form below.

<table>
<thead>
<tr>
<th>DENTAL PROGRAMS</th>
<th>ALLIED HEALTH PROGRAMS</th>
<th>NURSING PROGRAMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Assistant</td>
<td>Anesthesia Technology</td>
<td>Nursing Assistant</td>
</tr>
<tr>
<td>Dental Assistant Bilingual</td>
<td>Cardiovascular Technology</td>
<td>Nursing Assistant Bilingual</td>
</tr>
<tr>
<td>Dental Hygiene</td>
<td>Clinical Lab Technician</td>
<td>Practical Nursing</td>
</tr>
<tr>
<td>Dental Technician</td>
<td>Dietetic Technician</td>
<td>LPN-RN Educational Progression</td>
</tr>
<tr>
<td></td>
<td>Funeral Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health Information Technology</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health Unit Coordinator</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Healthcare Services Management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical Assistant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical Coding Specialist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical Interpreter Technician</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational Therapy Assistant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Optician-Vision Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pharmacy Technician</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phlebotomy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physical Therapy Assistant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Radiography</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Renal Dialysis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respiratory Therapist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Surgical Technologist</td>
<td></td>
</tr>
</tbody>
</table>

COMPLETE, INITIAL AND SIGN
Student Name: ___________________________ Student ID#: ___________________________

My program is:________________________________________________________

(Initial) I have read and understand the Essential Functions criteria specific to a student in my program indicated above.

(Initial) I am able to meet the Essential Functions as presented with or without accommodation.

(Initial) I was provided with information concerning accommodations or special service if needed at this time.

Note: The program you indicated above must be the program to which you have applied. Completion of this form verifies that you have read and understand the essential functions required. If you have applied to more than one program, this form must be completed for each of those programs.

__________________________ ______________
Signature Date

**I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.

Student Name: ___________________________ Signature: ___________________________ ID #: ___________________________

MATC is an Affirmative Action/Equal Opportunity Institution and complies with all requirements of the Americans with Disabilities Act
**Ocular History and Medical Laser Surveillance**

<table>
<thead>
<tr>
<th></th>
<th>Your History</th>
<th>Family History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blackouts</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Headaches</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Heart Problems</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Previous Eye Problems</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Retinal Problems</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Cataracts</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Thyroid Problems</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Other chronic medical problems</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

If you answered “yes” to any of the above questions, please clarify: ________________________________________________________________

Please list all of your current medications (include birth control and vitamins): _______________________________________________________

Please list all allergies to food, medication, or the environment: ________________________________________________________________

Have you ever worked with lasers before?  Yes No

If yes, what type of laser did you work with? ________________________________________________________________

Where did you work? ________________________________________________________________

What position did you hold? ________________________________________________________________

Have you ever been involved in a laser accident? Yes No

If yes, what were your injuries? ________________________________________________________________

Do you wear glasses? Yes No

Do you wear contacts? Yes No

If yes, for what purpose? ________________________________________________________________

Date of most recent eye exam: ________________________________________________________________

Student Signature: ___________________________________________ Date: ____________________________

Examine Results: ___________________________________________ Date: ____________________________

Examined By: ___________________________________________ Date: ____________________________
### Ocular History and Medical Laser Surveillance (cont.)

**Jaeger:**

Near point Acuity  
With/without Rx:  
O.D.  
O.S.  
O.U.  

### Color Vision:

O.D.  
O.S.  

### Distance Visual Acuity:

O.D.  
O.S.  
O.U.  

### Time:

Tonometer O.D.  
Readings O.S.  

### Keratometer:

O.D.  
Readings:  
O.S.  

### Recommended course action:

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

### Date:

_______________________________________________________
As a patient safety initiative, the School of Health Sciences at MATC requires influenza vaccinations for all students in all health programs.

**STUDENT INFORMATION:**

Name: __________________________________ Date of Birth: __________________________

Student ID#: __________________________ Program: __________________________________

**I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.**

Student Name: _________________________ Signature: ___________________________ ID #: ____________

For Clinic/Office Use only

____________________________________________________________________________________

Vaccine Information:

Vaccine Administered (Trade name): ______________________________ Vaccination Date: ________________

Vaccine Lot#: ______________________________

Facility Information:

Name of Location: ________________________________________________________________

Street Address: ______________________________ City: ________________________________

State: __________________ Zip/Postal Code: ________________________________

Phone Number: ______________________________

Name and Title of Vaccinator (Please Print): __________________________________________

Signature of Vaccinator: ___________________________ Date: ____________________
INSTRUCTIONS TO STUDENTS

PLEASE NOTE: You MUST make a copy of your completed health forms and retain it.
DO NOT UPLOAD UNLESS ALL RESULTS AND SIGNATURES ARE COMPLETE

SUMMARY OF MATERIALS TO BE COMPLETED

- (1) Physical Examination
- (2) Measles, Mumps and Rubella (MMR) Vaccination
- (3) Varicella (Chicken Pox) Vaccination
- (4) Tuberculosis Test
- (5) Tetanus Vaccination
- (6) Hepatitis B Vaccination
- (7) Handbook Acknowledgement
- (8) Liability Release
- (9) CPR Certification
- (10) Essential Functions Form
- (11) Ocular History and Medical Laser Surveillance (Eye Exam)
- (12) Influenza (Flu) Vaccination

If you have any Questions about uploading forms please contact:
Certified Background at 888-914-7279 or 414-297-7498, or email them to studentservices@certifiedprofile.com

(Revised 12/2012)