

MILWAUKEE AREA TECHNICAL COLLEGE
Health Occupations Division
Dietetic Technician Program

The next step in the admissions process is a health examination and completion of the required forms listed below. Please return all signed forms to the MATC Health Records/Criminal Background Check/Petition Office in Room M240 at the Milwaukee Campus. 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.

Included in this packet are:

1. Health Certification Form. Please have your physician or health care provider complete and sign the enclosed Health Certification Form.
2. Information about Hepatitis B and its vaccine, and a Hepatitis B Release Form. Please read the information and discuss it with your physician or health care provider. Complete and sign the Hepatitis Release Form.
3. Information about the essential functions for your program. Please read the information. If you have questions, discuss it with your physician or health care provider. Complete and sign the Essential Functions Form.

All forms must be completed with authorized signatures.

Return the completed Health Certification Form, the Hepatitis B Release Form and the Essential Functions Form to the MATC Health Records/Criminal Background Check/Petition Office in Room M240 at the Milwaukee Campus. If you have any questions, please contact the Health Records/Criminal Background Check/Petition Office at 414-297-6672.

Be sure to keep a copy of your completed forms.

We look forward to working with you as you complete the required documentation for your program of interest at MATC.

MATC Health Occupations Division

MILWAUKEE AREA TECHNICAL COLLEGE
Health Occupations Division
Essential Functions
for the
Dietetic Technician Program

The Americans with Disabilities Act (ADA) prohibits discrimination of persons with disabilities. In keeping with this law, MATC makes every effort to insure quality education for all students. It is our obligation to inform students of the essential functions necessary for this program and occupation.

Students requiring accommodation and/or special services to meet the essential functions of the program should contact the MATC Student Accommodation Services at any MATC campus.

The following physical, cognitive and environmental performance standards are encountered by students in this program.

ESSENTIAL FUNCTIONS

	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
SPEECH							
Speak English with Clarity				X		X	
Communicate in English with Clarity				X		X	
HEARING							
Conversation				X		X	
Telephone				X		X	
Machine Alarms Outside of Visual Field	X						X
Blood Pressure Alarms	X						X
Manual Blood Pressures	X						X
SIGHT							
Natural or Corrected Without Assistance				X		X	
Depth Perception				X		X	
Color Vision		X					X
Darkened Room	X						X

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	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
MOBILITY using <u>each</u> extremity (right <u>and</u> left) as applicable							
Lift, Push or Pull 25-40 lbs.		X				X	
Shoulder			X			X	
Arm			X			X	
Neck			X			X	
Standing			X			X	
Move about Facility			X			X	
Bending			X			X	
Crawling	X						X
Kneeling		X				X	
Twisting Body							
Running	X						X
Walking				X		X	
Climbing							
Stairs			X				X
Other							
MOVEMENT TRANSITIONS							
Supine to/from standing position			X				X
Supine to/from sitting position			X				X
Sitting to/from standing position			X				X
Kneeling on floor to/from standing position		X					X
Squatting to/from standing position		X					X

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	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
REACHING using <u>each</u> extremity (right <u>and</u> left) as applicable							
Overhead		X					X
In Front of Body				X		X	
Down		X					X
GRASPING							
Overhead		X					X
In Front of Body				X		X	
Down		X					X
SITTING			X			X	
SMELLING		X				X	
TASTING				X		X	
FINE MOTOR CONTROL (working with small objects and using each hand (right <u>and</u> left).							
Hands				X		X	
Fingers/Tactile Sense (the ability to feel when touching)				X		X	
Wrist				X		X	
COORDINATION							
Eye/Hand with both hands/arms				X		X	
Eye/Hand/Foot with both hands/arms/feet				X		X	
ALLERGIES/ SENSITIVITIES							
Tolerance to Latex		X					X
Other allergies to chemicals, etc.		X					X

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	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
COGNITIVE/MENTAL FACTORS				X		X	
REASONING				X		X	
Deal with abstract and concrete variables, define problems, collect data, establish facts, and draw valid conclusions				X		X	
Interpret instructions furnished in oral, written, diagrammatic, or schedule form				X		X	
Deal with problems varying from standard situations				X		X	
Carry out simple to complex writing and oral instructions				X		X	
Carry out at least one or two step instructions				X		X	
MATHEMATICS							
Complex skills - Business math, algebra, geometry or statistics			X			X	
Simple skills - add, subtract, multiply and divide whole numbers and fractions, calculate time and simple measurements			X			X	

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	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
READING							
Complex skills - Comprehend medical records, manuals, journals, instructions in use and maintenance of equipment, safety rules and procedures and drawings				X		X	
Simple skills - Comprehend simple instructions or notations from a log book				X		X	
WRITING							
Complex skills - Prepare medical documentation, report summaries using prescribed format and conforming to all rules of punctuation, spelling, grammar, diction and style				X		X	
Simple skills - English sentences containing subject, verb and object; names and addresses, complete job application or notations in a log book				X		X	

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	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
PERCEPTION							
Spatial - ability to comprehend forms in space and understand relationships of plane and solid objects; frequently described as the ability to "visualize" objects of two or three dimensions, or to think visually of geometric forms			X			X	
Form - ability to perceive pertinent detail in objects or in pictorial or graphic material; to make visual comparisons and discriminations and see slight differences in shapes and shadings of figures and widths and lengths of line			X			X	
CLERICAL							
Ability to perceive pertinent detail in verbal or tabular material; to observe differences in copy, to proof-read words and numbers, and to avoid perceptual errors in arithmetic computation.				X		X	
DATA							
Synthesizing				X		X	
Coordinating				X		X	
Analyzing				X		X	
Compiling				X		X	
Computing				X		X	

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	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
Copying				X		X	
Comparing				X		X	
PERSONAL TRAITS							
Ability to comprehend and follow instructions				X		X	
Ability to perform simple and repetitive tasks				X		X	
Ability to maintain a work pace appropriate to a given work load				X		X	
Ability to relate to other people beyond giving and receiving instructions				X		X	
Ability to influence people				X		X	
Ability to perform complex or varied tasks							
Ability to make generalizations, evaluations or decisions without immediate supervisor				X		X	
Ability to accept and carry out responsibility for direction, control and planning				X		X	
ENVIRONMENTAL FACTORS							
Works indoors				X		X	
Works outdoors	X						X
Exposure to extreme hot or cold temp		X				X	
Working at unprotected heights	X						X

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	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
Being around moving machinery		X				X	
Exposure to marked changes in temperature/humidity		X				X	
Exposure to dust, fumes, smoke, gases, odors, mists or other irritating particles (aerosol spray from equipment)		X				X	
Exposure to toxic or caustic chemicals		X				X	
Exposure to excessive noises		X				X	
Exposure to radiation or electrical energy	X						X
Exposure to solvents, grease, or oils		X				X	
Exposure to slippery or uneven walking surfaces		X				X	
Working in confined spaces		X				X	
Using computer monitor				X		X	
Working with explosives	X						X
Exposure to vibration		X				X	
Exposure to flames or burning items		X				X	
Works alone			X			X	
Works around others				X		X	
Works with others				X		X	
Exposure to Blood and Other Potentially Infectious Materials (OPIM)		X				X	

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	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
SAFETY EQUIPMENT (REQUIRED TO WEAR)							
Safety glasses		X					X
Face mask/face shield		X				X	
Ear plugs	X						X
Hard hat	X						X
Protective clothing		X					X
Protective gloves		X					X

If you have any questions or wish to discuss further the essential functions required of this program, please call the Health Occupations Division Office at 414-456-5326.

MILWAUKEE AREA TECHNICAL COLLEGE
Health Occupations Division
Essential Functions
for the
Dietetic Technician Program

_____ I have read and I understand the essential functions for this program.

_____ I have the ability to meet the essential functions as specified.

(Print Name of Program)

(Signed)

(Date)

The Americans with Disabilities Act (ADA) prohibits discrimination of persons with disabilities. In keeping with this law, MATC makes every effort to insure quality education for all students. It is our obligation to inform students of the essential functions necessary for this program and occupation.

Students requiring accommodation or special services to meet the essential functions of the program should contact the MATC Student Accommodation Services at any MATC campus.

_____ I require the following accommodations to meet the essential functions as specified and I have provided supporting documentation from my health care provider to the MATC Student Accommodation Services.

(Signed)

(Date)

MILWAUKEE AREA TECHNICAL COLLEGE

HEALTH OCCUPATIONS
HEALTH REQUIREMENTS CHECKLIST

- Check off as you complete each requirement for your own reference.
- Retain the completed list as program faculty may ask to see it at the beginning of a semester.

STUDENT NAME: _____

Program: _____

TO DO:

- Caregiver Background Check** (if required for your program; refer to our web page for a list of programs that require this)
- Acknowledgment of Essential Functions-Functional Abilities Form**
- Health Certification Requirements**
 - 1) **Certification of student's good health by a physician or nurse practitioner**
 - 2) **Immunizations** (Not required for CNA , Dental Technician or Optician Science)
 - a) MMR immunizations **1 and 2** **OR** Rubella Titer **AND**
 - b) Rubeola immunization or titer **AND**
 - c) Chicken pox - Proof of having had chicken pox or chicken pox immunization per authorized medical signature **OR** Varicella titer
 - 3) **TB skin test, Step 1 and Step 2** (Not required for Dental Technician or Opticianry Science)
(2 negative TB skin tests within 30 days of each other)
 - a) Chest x-ray, only if TB skin test was positive
 - 4) **Tetanus Shot**
 - 5) **Hepatitis B Release Form** - Signed and verifying Hepatitis B status
 - 6) **Hepatitis B immunization dates**
 - 7) **For Renal Dialysis Students Only:** Hepatitis B Antigen / Antibody
 - 8) **For Surgical Technology Students Only:** Eye Examination

The applicant must: 1). Return the original complete form to MATC, Nursing Center, Room M240. Name _____
2). Retain a copy to show instructor.

Program _____

MILWAUKEE AREA TECHNICAL COLLEGE
700 WEST STATE STREET
MILWAUKEE, WISCONSIN 53233

HEALTH CERTIFICATION

(Print Name and Address)

NAME: _____ BIRTHDATE: ____/____/____

ADDRESS: _____ City/State _____ Zip Code _____

PROGRAM NAME: _____ Semester Start _____ TELEPHONE #: _____

Cell Phone #: _____ E-Mail Address: _____

STUDENT ID # or SS# : _____ DATE DUE: _____

This form must be completed and returned
by the above stamped date

Were you in another Health Occupations program? Yes or No
If yes, what program? _____

Date you were in program _____

ONLY PHYSICIAN, PHYSICIAN ASSISTANT, 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 stationary, 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 _____
Street City State Zip Code

A full exam is on file at _____

IMMUNIZATIONS

Proof of at least two MMR's on or after the first birthday at least 30 days apart or laboratory evidence of rubella and measles immunity.

1) MMR _____
Date Authorized Signature & Medical Title

2) MMR _____
Date Authorized Signature & Medical Title

OR

Rubella Titer _____
Results Date Authorized Signature & Medical Title

AND

Rubeola Titer _____
Results Date Authorized Signature & Medical Title

-over-

The applicant must: 1). Return the original complete form to MATC, Nursing Center, Room M240. Name _____
 2). Retain a copy to show instructor.

Program _____

CHICKEN POX

Must have documentation of Health Care Provider Diagnosed Chicken Pox. If no documentation is available, must have a positive titer or documentation of vaccination.

RESULTS

Has this patient had:

Chicken Pox	_____	_____	_____	_____
	Yes	No	Date	Authorized Signature & Medical Title
OR				
Varicella Vaccine #1.	_____			_____
	Date			Authorized Signature & Medical Title
30 days later	#2. _____			_____
	Date			Authorized Signature & Medical Title
OR				
Varicella Titer	_____	_____	_____	_____
	Date	Results		Authorized Signature & Medical Title

TWO STEP MANTOUX TUBERCULIN SKIN TEST: This must be administered within one year of date of program entry or, if over one year, a ONE step update must be performed. Nursing Assistant Students must have skin test within 90 days of program beginning date.

PROCEDURE:

Step 1:

- 1). A Mantoux Tuberculin Skin Test of 0.1 (STU) PPD is administered to all individuals who have never had a two-step skin test or to those individuals who have not had a PPD within the last two years.
- 2). A health care professional must read the results within 48-72 hours.

If positive, must follow- up with a chest x-ray.

Step 2

- 1). Repeat the test within 7 to 30 days after the application of the first dose using the same strength of PPD.
- 2). A health professional must read the results within 48-72 hours.

If positive, must follow-up with a chest x-ray.

If negative, repeat (Step 1only) each year.

REPORTING RESULTS

4. Step 1 Results

_____	_____	_____	_____
Date Administered	Date Read	Results	Authorized Signature and Medical Title

4. Step 2 Results

_____	_____	_____	_____
Date Administered	Date Read	Results	Authorized Signature and Medical Title

4. ANNUAL UPDATE

_____	_____	_____	_____
Date Administered		Results	Authorized Signature and Medical Title

4. CHEST X-RAY (indicated only when Tuberculin Skin Test is Positive)

_____	_____	_____	_____
Date Administered	Date Read	Results	Authorized Signature and Medical Title

The applicant must: 1). Return the original complete form to MATC, Nursing Center, Room M240. Name _____
2). Retain a copy to show instructor.

Program _____

PROOF OF TETANUS IMMUNIZATION: (Within 10 years of program entry)

_____ Date

_____ Authorized Signature and Medical Title

PLEASE NOTE: You **MUST** make a copy of your completed health form and retain it. You may need to provide it to a clinical agency.

IMPORTANT

DO NOT RETURN UNLESS ALL RESULTS AND SIGNATURES ARE COMPLETE.

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

Signature of Student _____

INSTRUCTIONS TO STUDENTS

- Did your doctor or authorized medical person sign every authorized signature, dates and results of tests?
- Is your physical exam completed and all necessary information on the form completed?
i.e. (signature, print name, address, telephone #, test results, etc.)
- Do we have your home phone # on the space provided?
- Do you have a copy?

IF YOU HAVE ANY QUESTIONS, CALL THE NURSING CENTER

Joe Tuttle, at 414-297-7871
(Leave message if Joe Tuttle is unavailable)

OR
call

Nursing Center Reception Desk
414-297-6482
between the hours of
8:30 a.m. – 12:30 p.m.
Monday - Thursday

(s\admin\HLTHFRM2)
(Revised 2/11/03:vm)

*MATC is an Affirmative Action/Equal Opportunity Institution
and complies with all requirements of the Americans With Disabilities Act.*

MILWAUKEE AREA TECHNICAL COLLEGE
Health Occupations Division

INFORMATION ABOUT HEPATITIS B VACCINES

THIS GENERAL INFORMATION IS PROVIDED AS A COURTESY AND MATC MAKES NO REPRESENTATION AS TO IT'S ACCURACY. YOU SHOULD CONSULT YOUR PHYSICIAN FOR ALL MEDICAL INFORMATION REGARDING THE MATTERS GENERALLY DESCRIBED HERE.

The Disease and the Risks

Hepatitis B is a viral infection caused by the Hepatitis B virus (HBV) which causes death in 1-2% of patients. Most people with Hepatitis B recover completely, but approximately 2-10% become chronic carriers of the virus. Most of these people have no symptoms, but can continue to transmit the disease to others. Some may develop chronic active hepatitis and cirrhosis. HBV also appears to be a causative factor in the development of liver cancer. Thus, immunization against Hepatitis B can prevent acute hepatitis and also reduce sickness and death from chronic active hepatitis, cirrhosis and liver cancer.

Risk of Exposure

Medical and paramedical personnel are at increased risk of contracting hepatitis depending upon their degree of exposure to the blood or body fluids (e.g. saliva, feces, sweat, vaginal secretions, respiratory secretions and other body secretions) of patient infected with Hepatitis B (known or unknown). Hepatitis B is spread by direct contact of broken skin or mucous membranes with the blood or body fluids of a person who has Hepatitis B or is a carrier of the disease. Routine or frequent handling of blood or contaminated tissue products, therefore, constitutes significant risk because of the ease of transmission of the disease and the fact that many people with Hepatitis B have no symptoms and do not know they have the disease.

The first line of defense against Hepatitis B is the Hepatitis B vaccine. Immunization with Hepatitis B vaccine is the most effective method of preventing HBV infection.

The Vaccine

The Hepatitis B vaccine (Engerix B, Recombivax HB) is produced using recombinant DNA technology. The vaccine works by stimulating the immune system to produce antibodies to the virus.

The vaccine is given intramuscularly in the deltoid in three doses. The second dose one month after the first, and the third dose six- twelve months after the first. After vaccination, more than 90% of healthy adults develop protective antibodies. The cost is \$150.00 for the series. Only minor adverse reactions have been reported with vaccination, including transient fever and soreness at the injection site, rash, nausea joint pain and mild fatigue have also been reported. The vaccine is not contraindicated in pregnancy.

Reference

- a. Ganza, a., Torshner, L. (1997) Hepatitis Update. RN, 60 (12), 39-44.
- b. Hepatitis B Virus Vaccine Safety: Report of an Interagency Group: MMWR 31(34): 465
September 3, 1982.
- c. Hollinger, F. Blaine: Hepatitis B Vaccines-To Switch or Not to Switch. JAMA 257 (19): 2634-2636, May 15, 1987.
- d. Inactivated Hepatitis B Virus Vaccine: Annual of Internal Medicine 97:379-83, 1982.
- e. Jilg, W., et.a.: Clinical Evaluation of a Recombinant Hepatitis B Vaccine. The Lancet: 1174-1175, November 24, 1984.
- f. Krugman, Saul: The Newly Licensed Hepatitis B Vaccine. JAMA 247 (14): 2012-15, April 1992.
- g. Leads from the MMWR: Recommendations of the Immunization Practices Advisory Committee Update on Hepatitis B Prevention. JAMA 258(4): 437-449, July 24/31, 1987.
- h. Lewis, S., Heitkemper, M., Dirkson, S., (2000). Medical Surgical Nursing. 1193-1198. Mosby.
- i. Medical College of Wisconsin, Student Health Services.

Name _____
Program _____

MILWAUKEE AREA TECHNICAL COLLEGE
Health Occupations Division

RELEASE FORM: HEPATITIS B

1

Please read thoroughly and check the appropriate box.

I have received and read the information regarding Hepatitis B and the vaccines that are available.

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. I understand that full immunity requires three doses of vaccine over a six-month period.

Student signature required _____ Signature of Student _____ Date _____

2

Return this form to the Health Center as soon as possible with any information listed. Please have authorized medical signature if you have had any dosages.

IF HBV given:

1st Dose Date: _____
Authorized Medical Signature _____

2nd Dose Date: _____
Authorized Medical Signature _____

3rd Dose Date: _____
Authorized Medical Signature _____

Please Return this Form to:
MATC Health Center (Room M240)
700 West State Street
Milwaukee WI 53233