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

All MATC Health Science students are required to complete criminal background check, drug testing and health requirements after being accepted through the petition process for their program. MATC School of Health Sciences has partnered with Certified Background.com to provide record tracking for all MATC Health Sciences students. The cost of all record tracking is the responsibility of the student.

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

- Visit CertifiedBackground.com website: www.certifiedbackground.com
- Look for the place order box on the homepage.
- Enter the package code MF49 (package code is specific to the Surgical Technology program)
- Follow the directions to setup your CB account

* The cost of the criminal background check, drug testing, 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.

**HEALTH REQUIREMENTS** (Forms attached for your use)

- (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

**OTHER**

- Criminal Background Check (Refer to CertifiedBackground.com)
- Drug Testing (Refer to CertifiedBackground.Com)
MATC is an Affirmative Action/Equal Opportunity Institution and complies with all requirements of the Americans with Disabilities Act.

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

**OR**

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

30 Days later

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

**OR**

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

Date Read  Results  ___________________          ______________  ___________________  ___________________                            ___________________________________________  Date Administered

2. Step 2 Results

Date Read  Results  ___________________          ______________  ___________________  ___________________                            ___________________________________________  Date Administered

Chest X-Ray (if required)

Date Read  Results  ___________________          ______________  ___________________  ___________________                            ___________________________________________  Date Administered

TB Gold Titer (if required)

Date Read  Results  ___________________          ______________  ___________________  ___________________                            ___________________________________________  Collection Date

Annual Update

Date Read  Results  ___________________          ______________  ___________________  ___________________                            ___________________________________________  Date Administered

**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 #: ______________________
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#   __________________
Date

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 #: ____________________

MATC is an Affirmative Action/Equal Opportunity Institution and complies with all requirements of the Americans with Disabilities Act
ACCEPTANCE OF RISKS AND RESPONSIBILITY AGREEMENT
AND RELEASE OF LIABILITY

This Acceptance of Risks and Responsibility Agreement and Release of Liability ("Agreement and Release") is executed by: [Student Name] (please print student first and last name ("Participant") and is issued to Participant is participating in a COLLEGE affiliated Program/Course/Practicum/ Training/Activity ("Activity"). This Activity is more fully described in each of the MATC School of Health Sciences program pages, which have been provided to Participant.

Participant understands that there are certain dangers, hazards, and risks inherent in the Activity. These include, but are not limited to, 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. In certain circumstances, these dangers can include damage/destruction to property, severe bodily injury, and even death.

Participant agrees to exercise reasonable care at all times with respect to Participant’s own safety and with respect to the safety of others. Participant agrees to abide by all rules, policies and procedures of the COLLEGE that are set forth in the Code of Conduct found in the COLLEGE’s Student Handbook, as well as any additional rules, policies and procedures of the location of the Activity. Participant has no health-related issues that would preclude or restrict participation in the Activity.

Accordingly, Participant, on behalf of him/herself, the Participant’s spouse (if applicable), the Participant’s heirs, assigns, related individuals and related entities, does hereby WAIVE, RELEASE, AND DISCHARGE the COLLEGE, including its Board of Trustees/Directors, administrators, officers, employees, teachers, agents and insurers, from any and all claims, causes of action, suits, damages, or liabilities sounding in negligence, which the Participant has, shall have, or may have in the future against the COLLEGE arising out of, based on, related to, or connected with, the Participant’s enrollment and participation in the Activity. This release of liability does not, however, apply to any intentional or reckless acts or conduct by the COLLEGE.

This Agreement and Release shall be governed by the laws of the State of Wisconsin, which shall be the forum for any lawsuits filed under, or incident to, this Agreement and Release.

By signing this document, Participant acknowledges that s/he is fully informed of the contents of this Agreement and Release, and represents that s/he understands it. Participant is not relying on any oral or written representations, statements or inducements, apart from those made in this Agreement and Release.

Participant is at least eighteen (18) years of age, and is competent to sign this document. If Participant is a minor under the age of eighteen (18), the parent and/or guardian acknowledges they are competent to sign this document on behalf of the Participant.

By signing this Agreement and Release, you give up substantial legal rights. Read and understand this entire document before you sign it.

_________________________  __________________________
Participant                        Date

_________________________  __________________________
Parent/Legal Guardian (Signature required if Participant is under age 18.)  Date

(doc...revised 7-25-13)

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

### DENTAL PROGRAMS
- Dental Assistant
- Dental Assistant Bilingual
- Dental Hygiene
- Dental Technician

### ALLIED HEALTH PROGRAMS
- Anesthesia Technology
- Cardiovascular Technology
- Clinical Lab Technician
- Dietetic Technician
- Funeral Service
- Health Information Technology
- Health Unit Coordinator
- Healthcare Services Management
- Medical Assistant
- Medical Coding Specialist
- Medical Interpreter Technician
- Occupational Therapy Assistant
- Optician-Vision Care
- Pharmacy Technician
- Phlebotomy
- Physical Therapy Assistant
- Radiography
- Renal Dialysis
- Respiratory Therapist
- Surgical Technologist

### NURSING PROGRAMS
- Nursing Assistant
- Nursing Assistant Bilingual
- Practical Nursing
- LPN-RN Educational Progression
- Registered Nursing

**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 #: ___________________________
Ocular History and Medical Laser Surveillance

<table>
<thead>
<tr>
<th>Have you, or someone in your family ever had any of the following:</th>
<th>Your History</th>
<th>Family History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blackouts</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Headaches</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Heart Problems</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Previous Eye Problems</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Retinal Problems</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Cataracts</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Thyroid Problems</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other chronic medical problems</td>
<td>Yes</td>
<td>No</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: ________________________________
<table>
<thead>
<tr>
<th>Jaeger:</th>
<th>Color Vision:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Near point Acuity</td>
<td>O.D. ____/9</td>
</tr>
<tr>
<td>With/without Rx:</td>
<td>O.S. ____/9</td>
</tr>
<tr>
<td>O.D.</td>
<td>____________</td>
</tr>
<tr>
<td>O.S.</td>
<td>____________</td>
</tr>
<tr>
<td>O.U.</td>
<td>____________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Distance Visual Acuity:</th>
<th>Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td>O.D.</td>
<td>____________</td>
</tr>
<tr>
<td>O.S.</td>
<td>____________</td>
</tr>
<tr>
<td>O.U.</td>
<td>____________</td>
</tr>
<tr>
<td>Tonometer O.D.</td>
<td></td>
</tr>
<tr>
<td>Readings O.S.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Keratometer:</th>
<th>Readings:</th>
</tr>
</thead>
<tbody>
<tr>
<td>O.D.</td>
<td><strong><strong><strong><strong><strong><strong>/</strong></strong></strong></strong></strong></strong>_____</td>
</tr>
<tr>
<td>O.S.</td>
<td><strong><strong><strong><strong><strong><strong>/</strong></strong></strong></strong></strong></strong>_____</td>
</tr>
</tbody>
</table>

**Recommended course action:**

___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________

Date: ____________________________________________

---

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

<table>
<thead>
<tr>
<th>SUMMARY OF MATERIALS TO BE COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Requirements</strong></td>
</tr>
<tr>
<td>❑ (1) Physical Examination</td>
</tr>
<tr>
<td>❑ (2) Measles, Mumps and Rubella (MMR) Vaccination</td>
</tr>
<tr>
<td>❑ (3) Varicella (Chicken Pox) Vaccination</td>
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<td>❑ (12) Influenza (Flu) Vaccination</td>
</tr>
<tr>
<td><strong>Other</strong></td>
</tr>
<tr>
<td>❑ Criminal Background Check (refer to CertifiedBackground.com)</td>
</tr>
<tr>
<td>❑ Drug Testing (refer to CertifiedBackground.com)</td>
</tr>
</tbody>
</table>

If you have any questions about uploading forms:

Call or email Certified Background at 888-914-7279 or studentservices@certifiedprofile.com

or call the MATC School of Health Sciences at 414-297-6263.

(Revised 10/2013)