MILWAUKEE AREA Technical College

## 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: _____ OfficeTelephone #_____**

**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 #:*** _____

MILWAUKEE AREA Technical College

## Varicella (Chicken Pox) Vaccination
## (3)

**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?**

**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*

***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 #:*** _____

MILWAUKEE AREA Technical College

# Tuberculosis Test
**(4)**

## 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* | *Authorized Signature & Medical Title* | *Date Administered* |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

**2. Step 2 Results**

| *Date Read* | *Results* | *Authorized Signature & Medical Title* | *Date Administered* |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

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

| *Date Read* | *Results* | *Authorized Signature & Medical Title* | *Date Administered* |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

**TB Gold Titer (if required)**

| *Date Read* | *Results* | *Authorized Signature & Medical Title* | *Date Administered* |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

**Annual Update**

| *Date Read* | *Results* | *Authorized Signature & Medical Title* | *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 #:*** _____

MILWAUKEE AREA Technical College

## Tetanus Vaccination
## (5)

**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 #:*** _____

MILWAUKEE AREA Technical College

## Hepatitis B Vaccination
**(6)**

**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. I 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 #:*** _____

MILWAUKEE AREA Technical College

## Liability Release
## (8)

**ACCEPTANCE OF RISKS AND RESPONSIBILITYAGREEMENT AND RELEASE OF LIABILITY**

This Acceptance of Risks and Responsibility Agreement and Release of Liability ("Agreement and Release") is executed by: _____ (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

MILWAUKEE AREA Technical College

**CPR Certification**
**(9)**

## CPR Verification:

**American Heart Association 2-year BLS Healthcare Provider level only.**

**Sign your CPR card and upload a copy of the FRONT and BACK of the card to castlebranch.com.**

**MATC offers this CPR course. You can check for course offerings (PHYED-441) and register thru Self Service.**

**Self-Service link**

**Other vendors that offer American Heart Association CPR training:**

**First Aid Plus**

**Badgerland CPR & First Aid**

**Advanced Professional Healthcare Education, LLC**

**Healthline First Aid, LLC**

**Paratech Community Training Center**

MILWAUKEE AREA Technical College

# Essential Functions Signature Form
## (10)
***(Upload this page only)***

## 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 | ALLIED HEALTH PROGRAMS | NURSING PROGRAMS |
|---|---|---|
| Dental Assistant | Anesthesia Technology | Nursing Assistant |
| Dental Assistant Bilingual | Cardiovascular Technology - Echocardiography | Practical Nursing |
| Dental Hygiene | Cardiovascular Technology – Invasive | Practical Nursing LPN-RN Educational Progression |
| | Central Service Technician | Registered Nursing |
| | EKG Technician | |
| | Health Information Technology | |
| | Healthcare Services Management | |
| | Health Unit Coordinator | |
| | Medical Assistant | |
| | Medical Coding Specialist | |
| | Medical Interpreter | |
| | Medical Laboratory Technician | |
| | Nutrition and Dietetic Technician | |
| | Occupational Therapy Assistant | |
| | Pharmacy Technician | |
| | Phlebotomy | |
| | Physical Therapist Assistant | |
| | Radiography | |
| | Renal Dialysis Technician | |
| | Respiratory Therapist | |
| | Surgical Technology | |

## 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.

**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 #:*** _____

MILWAUKEE AREA Technical College

## Influenza (Flu) Vaccination
## (11)

As a patient safety initiative, the Healthcare Pathway 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**

⇩ ⇩

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**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:** _____

MILWAUKEE AREA Technical College

**Health Insurance Portability Accountability Act (HIPAA Training)**
**(12)**

Student is to complete HIPAA Training provided by the North American Learning Institute by following the process below.

HIPAA Training website is https://nalearning.org/hipaa/MATC provided by the North American Learning Institute

- Create an Account
- Training cost is $15
- One hour of minimal training for course. Must preview all pages, cannot skip to post test and will time out if page is left open and no activity recorded. You can stop and start course. Extra Authentication for log in.
- Must score at least 70% or greater for successful completion on Post Test. You can retake Post Test to pass.
- Course can be taken on Desktop, Laptop, Tablet or Phone
- 24/7 Support provided by the North American Learning Institute for Login or technical issues via Text, Phone or Email.
- Customer Service Phone - (407) 906-6254 • Customer Service Email - Help@nalearning.org • Privacy Policy

Upload Successful Course Completion Certificate to CastleBranch Profile


Certificate of Completion
This certifies that the person named below has completed a
1 Hour HIPAA Training Class
and has passed a written knowledge assessment
COURSE FOR HIPAA
HIPAA TRAINING CLASS
Name
City, State
Date of Course Completion:
Valid for 1 Year
Certificate Number:

By completing this training, I acknowledge that I agree to abide by the terms and conditions found in the contents of the HIPAA training course.

MILWAUKEE AREA Technical College

**Drug Test Verification Form**
**(13)**
***(Upload this page only)***

## Drug Test Verification:

I acknowledge that my drug test **RESULTS** were posted on my CastleBranch, Inc. profile on (date)**:** _____

**Note: You must upload the drug test verification form in your health requirements profile after ordering/paying/completion of the drug test itself. This form prompts CastleBranch to enter the next due date for the drug test requirement.**

**Student Signature:** _____

**Student Name:** *(Please print)* _____

**Student MATC ID number:** _____

**Signature Date:** _____

MILWAUKEE AREA Technical College

**Criminal Background Check (CBC) & Self-Disclosure (BID)**
**Verification Form**
**(14)**
***(Upload this page only)***

## Criminal Background Check (CBC) & Self-Disclosure (BID) Verification Form:

Date of last Criminal Background Check (CBC): _____

Date of last Self-Disclosure (BID): _____

Note: You complete and upload this CBC-BID verification form in your health requirements profile ***after*** ordering/purchasing and completion of the CBC/BID itself. This form prompts CastleBranch to enter the next due date for the CBC/BID requirement.

**Student Signature:** _____

**Student Name:** *(Please print)* _____

**Student MATC ID number:** _____

**Signature Date:** _____

**Criminal Background Check (CBC) & Self-Disclosure (BID) must be renewed every 2 years.**

MILWAUKEE AREA Technical College

**Covid-19 Vaccination Completion**
**(15)**

## Covid-19 Vaccination Completion Process:

**Upload a copy of your Wisconsin Immunization Record (WIR) or Electronic Health Record (EHR) to your CastleBranch profile**

MILWAUKEE AREA Technical College

# INSTRUCTIONS TO STUDENTS

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

**SUMMARY OF MATERIALS TO BE COMPLETED**

**Health Requirements**

1.) Physical Examination Form
2.) Measles, Mumps and Rubella (MMR) Vaccination Form
3.) Varicella (Chicken Pox) Vaccination Form
4.) Tuberculosis Test Form
5.) Tetanus Vaccination Form
6.) Hepatitis B Vaccination Form
7.) Handbook Acknowledgment Form
8.) Liability Release Form
9.) CPR Certification (upload front/back of signed/dated Certification)
10.) Essential Functions Form (upload this page only)
11.) Influenza (Flu) Vaccination Form
12.) Health Insurance Portability and Accountability Act (HIPAA) (upload copy of Course Completion Certificate)
13.) Drug Test Verification Form (upload this page only)
14.) CBC/BID Verification Form (upload this page only)
15.) Covid-19 Vaccination - Proof of Completion

**Other**

- Criminal Back Check (refer to castlebranch.com)
- Drug Testing (refer to castlebranch.com)

**Call or email CastleBranch, Inc. at 888-914-7279 or studentservices@castlebranch.com**

**or call the MATC Healthcare Pathway at 414-297-6263** or email at healthpathway@matc.edu