All MATC Health Science students are required to complete criminal background check, drug testing and health requirements* AFTER being selected** through the petition process for their program. After being selected to continue the petition process, you will need to complete additional steps before being fully admitted to your program.

Once you have been selected to move forward in the petition process, you must complete a mandatory orientation where instructions for completing these requirements will be provided. The forms below will be used to complete the program requirements.

* 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 IMPACT@ 1-866-211-3380 for a list of clinics in your area.

**Please note that being selected through the petition process, does not guarantee full admission to your program.

DO NOT UPLOAD UNLESS ALL RESULTS AND SIGNATURES ARE COMPLETE!

If you have any questions about uploading forms, call the MATC Petition Office at 414-297-6088 or contact CastleBranch, Inc. at 888-914-7279 or studentservices@castlebranch.com

HEALTH REQUIREMENTS (Forms attached for your use)

- [ ] (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 Acknowledgement Form
- [ ] (8) Liability Release Form
- [ ] (9) Essential Functions Signature Form (upload this page only)
- [ ] (10) Influenza (Flu) Vaccination Form
- [ ] (11) Drug Test Verification Form (upload this page only)
- [ ] (12) Health Insurance Portability and Accountability Act (HIPAA) Acknowledgment Form
OTHER

☐ Criminal Background Check (Refer to castlebranch.com)
  Note: You must disclose everything that is part of your record on the self-disclosure form (BID), regardless of the outcome. All MATC clinical affiliates reserve the right to deny student placement at their facilities. If placement is denied, you will not be able to complete or graduate from your program.

☐ Drug Testing (Refer to castlebranch.com)
  Note: You must upload the drug test verification form in your health requirements profile.
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
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 #: ____________
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?
Chicken Pox

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

OR

Varicella Vaccine #1

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

30 Days later

Varicella Titer

<table>
<thead>
<tr>
<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)

<table>
<thead>
<tr>
<th>Step</th>
<th>1. Step 1 Results</th>
<th>2. Step 2 Results</th>
<th>Chest X-Ray (if required)</th>
<th>TB Gold Titer (if required)</th>
<th>Annual Update</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Date Read</td>
<td>Results</td>
<td>Authorized Signature &amp; Medical Title</td>
<td>Date Administered</td>
<td>Date Read</td>
</tr>
<tr>
<td></td>
<td></td>
<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 #:** ___________________________
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 #: ____________________
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: __________________________________________________
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: ________________________________________________________________ (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

MATC is an Affirmative Action/Equal Opportunity Institution and complies with all requirements of the Americans with Disabilities Act (rev 7/2018)
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.

<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>Registered Nursing</td>
</tr>
<tr>
<td></td>
<td>Health Information Technology</td>
<td></td>
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<td></td>
<td>Health Unit Coordinator</td>
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<td></td>
<td>Healthcare Services Management</td>
<td></td>
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<tr>
<td></td>
<td>Medical Assistant</td>
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<tr>
<td></td>
<td>Medical Coding Specialist</td>
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<tr>
<td></td>
<td>Medical Interpreter Technician</td>
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<tr>
<td></td>
<td>Occupational Therapy Assistant</td>
<td></td>
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<tr>
<td></td>
<td>Optician-Vision Care</td>
<td></td>
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<tr>
<td></td>
<td>Pharmacy Technician</td>
<td></td>
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<tr>
<td></td>
<td>Phlebotomy</td>
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<tr>
<td></td>
<td>Physical Therapy Assistant</td>
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<td></td>
<td>Radiography</td>
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<td></td>
<td>Renal Dialysis</td>
<td></td>
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<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.

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  (rev 7/2018)
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 #: __________________

---

**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: __________________

---

MATC is an Affirmative Action/Equal Opportunity Institution and complies with all requirements of the Americans with Disabilities Act (rev 7/2018)
**Drug Test Verification:**

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

Student Signature: _____________________________________________________________

Student Name: *(Please print)* ____________________________________________________

Student MATC ID number: ______________________________________________________

Signature Date: __________________________________________________________________
I acknowledge that I am responsible for the contents of the current School of Health Sciences HIPAA Training located on the MATC website.

1. HIPAA-Privacy Rule for Covered Entities
2. HIPAA- Security Rule for Covered Entities

I further agree to abide by the terms and conditions found in the contents of the HIPAA training courses.

Student Signature: ________________________________

Student Name: (Please print) ________________________________

Student MATC ID Number: ________________________________

Signature Date: ________________________________

***Information to access the training will be provided by the program coordinator.***

**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 #: ________________
# 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><strong>SUMMARY OF MATERIALS TO BE COMPLETED</strong></th>
</tr>
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<tbody>
<tr>
<td><strong>Health Requirements</strong></td>
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<td>❑ (1) Physical Examination Form</td>
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**If you have any questions about uploading forms:**

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

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