SUNY SCHENECTADY
COUNTY COMMUNITY COLLEGE

Community Health Worker (CHW), Behavioral Health Tech (BHT), Office of Workforce Development & Community Education

Required Medical Forms Pre-Training

Preliminary Review of Records

Case Manager Name and affiliation _____(if applicable)

Student Name		Circle one if applicable		Reviewer
Physical Exam form within 10 months of training class with Training Clearance signed by Physician. Clearance to work with no restrictions • If pregnant, clearance from OB/GYN **(Complete ALL Boxes to the right)**	Physician Signature **date**: _____	Clearance to work with no restrictions **Yes No** **If Pregnant, OB clearance___**	Clearance to work with the elderly **Yes No**	
MMR -Rubeola (Measles), Rubella (German Measles), Mumps **(Complete ONE Box to the right)** ***Requirements:* One** of these must apply: 1. If born before 1957 – exempt from this req. 2. If born after 1957, 2 doses of MMR vaccine (and at least one month apart) 3. Proof of Titre showing immunity (Positive)	**Date:** #1_____ #2_____	Titre results show Immunity **Date:** _____	Born before **1957** and exempt _____ Student Initial	_____
Tetanus-Diptheria or TDaP (with Pertussis) vaccine ***Requirement:* Must be given within the last 10 years **(Complete ONE Box to the right)**	**Date** Given: _____			
Menomune/Meningococcal Meningitis vaccine ***Requirement:* (Complete ONE Box to the right)** 1. Vaccine given 2. Date Declination form signed	**Date** given: _____	Declination Signed **Date**: _____		
Varicella Zoster (Chicken Pox) ***Requirement: (Complete ONE Box to the right)** 1. Vaccine given or proof of Titer	**Date** given: _____			
Hepatitis B Immunization Dates ***Requirement:* (Complete ONE box to the right)** 1. Dates of three doses in series 2. Series completion date if dose dates is unavailable 3. Date declination form signed	#1 #2 #3	Series completion **Date:** _____ _____	Declination Signed **Date:** _____ _____	

Record is Complete on (Date) _____ R.N. Reviewer Signature_____