HEALTH PROFESSIONAL PROGRAMS:

IMMUNIZATION REQUIREMENTS

Wellness Center – Main Campus, Room 118

Your completed form and supporting document(s) must be uploaded into your CastleBranch account.

For assistance with account activation, or to receive your program specific package code, please contact the Wellness Center: (716) 827.2579 | WellnessCenter@trocaire.edu

For assistance with CastleBranch, please contact CastleBranch Student Support: (888) 723.4263

PART 1: STUDENT INFORMATION - To be completed by the student and/ or guardian

STUDENT LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH

( ) -

PREFERRED PHONE	STREET ADDRESS	CITY	STATE	ZIP CODE

EMAIL	STUDENT ID (IF KNOWN)

For students entering Health Professional Programs, the following information must be submitted to CastleBranch prior to attending clinical:

- **Physical Examination-** Please have your medical provider complete a Trocaire College Physical Form.
- **Annual Flu Shot –** Please submit proof of immunization for current flu season (August through May); or submit an annual signed declination (note: face mask must be worn per site compliance if declined)
- **COVID-19 Vaccination** – Proof of immunization against Coronavirus disease (see acceptable proof below)
- **CPR Certification**
- **HIPAA TRAINING –** Valid for one year; students may submit the certificate received through SafeColleges

In addition to information above, students in health profession programs will be asked to submit record of the immunizations listed in Part 2 of this form (varies by program – please refer to your program student handbook). Proof of Immunizations may be submitted, ***or*** information below may be completed and signed off by a medical provider.

ACCEPTABLE PROOF OF IMMUNITY MAY INCLUDE:

(1) Original immunization cards from childhood (yellow card), signed and stamped.
(2) Immunization records from college, high school or other schools you attended.
(3) Signed and stamped immunization record from your health care provider or clinic.
(4) Proof of DD 214 from the armed services within 10 years from the date of application will enable the student to attend school pending actual receipt of the immunization records from the armed services.

STUDENT LAST NAME FIRST NAME MIDDLE INITIAL DATE OF BIRTH

PART 2: IMMUNIZATION HISTORY - To be completed and signed by student's medical provider *or* student may submit proof of immunity.

VARICELLA VACCINE: Two doses, disease date, or serology required.

Dose 1: ___ / ___ / _____ Dose 2: ___ / ___ / _____

Disease Date: ___ / ___ / _____ Serology: ___ / ___ / _____ **Immune?** (circle one) **Yes** or **No**

TETANUS, DIPHTHERIA, PERTUSSIS: One booster within last 10 years (single dose of TDap recommended)

TDap Date: ___ / ___ / _____ TD Date: ___ / ___ / _____

TST SKIN TEST: Required for all students in health professional programs (annual)

Date Administered: ___ / ___ / _____

Induration: _____mm Date of reading: ___ / ___ / _____ Time of Reading ___ :___ AM/ PM

Please note: If TST is 15mm or greater a copy of a chest x-ray is required.

HEPATITIS:

Option 1: HEPATITIS B: 1. ___ / ___ / _____ 2. ___ / ___ / _____ 3. ___ / ___ / _____

Option 2: Refusal to accept Hepatitis B Vaccine
I understand that due to my possible exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. 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.

Student Signature: _____ Print Name: _____ Date: ___ / ___ / _____

_____	_____	___ / ___ / _____
Provider Name (Printed)	Provider Signature	Date

_____
Provider Address & Phone