

NORTH COUNTRY COMMUNITY COLLEGE

Nursing Program

TO: Nursing Students and Faculty

Subject: Hepatitis B Information Sheet

I understand that, due to my attendance in clinical experience, exposure to blood or other potentially infectious materials is a very real possibility. As a result of a possible exposure, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. North Country Community College has recommended that I receive the series of Hepatitis B vaccinations as an effective way of protecting myself from acquiring this infection. I understand that it is, however, my choice to make and that whatever I decide will not affect my status at NCCC.

I further understand that if I make the decision to decline the series of HBV vaccinations, I continue to be at risk of acquiring Hepatitis B, a serious disease. I also understand that my risk may be decreased by maintaining certain behaviors in the clinical setting and that these behaviors will be taught to me prior to entry into the clinical practicum. I further understand that learning these behaviors and maintaining these techniques and behaviors in the clinical setting are primarily my responsibility. I fully understand, however, that total protection can only be achieved by having active immunity for Hepatitis B.

In the event that I choose not to receive the series of HBV vaccinations, I take full responsibility for my decision and will not hold NCCC or the clinical agency in which I learn and practice my skills responsible if I should acquire the Hepatitis B virus. If I do choose to receive the series of HBV vaccinations, I understand that I (not NCCC) am responsible for any and all expenses incurred as a result of my decision to receive these vaccinations and/or titers.

To be permitted to enter a clinical area, all Allied Health Program faculty and students must read, complete, date and sign this form.

MY DATED SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THE PRECEDING INFORMATION ABOUT **HEPATITIS B** AS IT RELATES TO MY STATUS AS FACULTY OR STUDENT IN AN ALLIED HEALTH PROGRAM, THAT I MUST MAKE A DECISION TO:

SUBMIT A COPY OF THE SERIES OF HBV VACCINATIONS (3 shots)
OR

SUBMIT A COPY OF LAB RESULTS SHOWING A POSITIVE TITER

OR

DECLINE THE SERIES OF HBV VACCINATIONS

Print Name

Signature

Date

CONTROL OF HEPATITIS INFECTION

- a. Personnel who are suspected of being infected with hepatitis A virus (HAV) should not take care of patients until 7 days after the onset of jaundice. CATEGORY III
- b. Screening for evidence of prior infections with hepatitis B virus (HBV) in personnel who work in dialysis centers or other high-risk areas should be done only when needed to institute appropriate control measures. CATEGORY I
- c. Personnel who are known carriers of HbsAg should be counseled about precautions to minimize their risk of infecting others. CATEGORY I
- d. 1) Personnel who have no exudative lesions on the hands and who are acutely infected with HBV, are known to be carriers of HbsAg, or have hepatitis non A/non B (NANB) should not be restricted from patient-care responsibilities, unless there is evidence of disease transmission. CATEGORY I
2) Personnel who have no exudative lesions on the hands and who are acutely infected with HBV, are known to be carriers of HbsAg, or have hepatitis NANB should wear gloves for procedures that involve trauma to tissues or direct contact with mucous membranes or non-intact skin. CATEGORY II
- e. Personnel with exudative lesions on the hands who are HbsAg-positive should either wear gloves for all direct patient contact and when handling equipment that will touch mucous membranes or non-intact skin or abstain from all direct patient care. CATEGORY I
- f. Dental personnel should consider routine use of gloves, masks, and protective eyewear when performing dental procedures. CATEGORY III

These suggestions are not meant to restrict hospitals from using additional precautions.

NORTH COUNTRY COMMUNITY COLLEGE

MMR Immunization Validation Form

Name: _____ Other Names Used: _____

Address: _____ Date of Birth _____

NY State Public Health Law 2165 requires all post-secondary students born on or after January 1, 1957, and enrolled in six or more credit hours, to provide proof of immunity to measles, mumps, and rubella. Appropriate documentation must include ONE of the following:

- Documentation of TWO (2) MMR vaccinations. To be considered valid, the first vaccination cannot be administered any more than four days prior to the student's first birthday, and the second dose must be given at least 28 days after the first dose.
- Documentation of TWO (2) doses of the measles vaccination, ONE (1) dose of the mumps vaccination, and ONE (1) dose of the rubella vaccination. To be considered valid, neither vaccination can be administered any more than four days prior to the student's first birthday, and the SECOND dose of the measles vaccination must be given at least 28 days after the first dose.
- POSITIVE blood titer results for measles, mumps, and rubella. Copies of a lab report(s) validating these results must be submitted.

To assist with documenting one of the above options, you may choose to have your health care provider complete this form. Please note that, if you are able to obtain a copy of your immunization record from another source (high school, another college, etc.), it is NOT necessary to complete this form. However, it is necessary to submit the "Meningococcal Disease Response Form" contained in this packet.

To be completed by a health care provider, NOT the student or student's parent/guardian

OPTION 1	OPTION 2
Date of MMR #1 _____	Date of POSITIVE Blood Titers
Date of MMR #2 _____	<i>A copy of lab report must be attached to verify results.</i>
<u>OR</u>	
Date of Measles #1 _____	+ Measles Blood Titer Date _____
Date of Measles #2 _____	
Date of Mumps #1 _____	+ Mumps Blood Titer Date _____
Date of Rubella #1 _____	+ Rubella Blood Titer Date _____

The above vaccination(s) have been validated by:

Health Care Provider name (printed) _____

Telephone Number _____

Address _____
Street City State Zip

HCP's Signature _____

Date _____

The medical office's stamp validating this information can be used in lieu of the provider's signature.

Please fax this completed form to 518-891-4236 OR Email to healthrecords@nccc.edu

NORTH COUNTRY COMMUNITY COLLEGE
Nursing Program

TO: Nursing Students and Faculty

Subject: Varicella (Chicken Pox) and Zoster (Shingles)

- | |
|--|
| <input type="checkbox"/> I have had a Varicella Titer (please submit evidence of titer with this form.)
OR
<input type="checkbox"/> I have received the immunization series (2 shots) for varicella/chickenpox
(Submit appropriate evidence of immunizations with this form). |
|--|

I understand that if I do not have immunity to Varicella, I could contract the disease in the form of Shingles (Zoster) or Chicken Pox (Varicella). I also understand that if I do contract either disease, I could spread it to patients (particularly those with a decrease in immunity) unknowingly during the prodromal stage of the disease which may run from 10 days post exposure to the end of the incubation period of 21 days post exposure.

Therefore, I understand that if I do not have a positive Varicella titer, I would be professionally negligent in reporting to a clinical area in the event that I do become exposed to either disease.

I further understand that if I do contract Varicella or Zoster, I will not return to patient care until all lesions have dried and crusted.

MY DATED SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT, IF I DO NOT HAVE A POSITIVE TITER FOR VARICELLA OR AM NOT POSITIVE THAT I HAVE IMMUNITY TO VARICELLA, I WILL COMPLY WITH THE ABOVE POLICY.
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CDC Guidelines Nosocomial Infections

8. PERSONNEL EXPOSED TO VARICELLA OR ZOSTER
 - a. After exposure to varicella (chickenpox) or zoster (shingles) personnel not known to be immune to varicella (by history or serology) should be excluded from work beginning on the tenth day after exposure and remain away from work for the maximum incubation period of varicella (21 days).
CATEGORY I
 - b. Personnel who have onset of varicella should be excluded from work at least until all lesions have dried and crusted.

These suggestions are not meant to restrict hospitals from using additional precautions. **Return signed form to: Nursing Medical Records**

Print Name: _____

Signature: _____ Date: _____

NORTH COUNTRY COMMUNITY COLLEGE

Meningococcal Disease Response Form

Students Name: _____ Other Names Used: _____

Address: _____ Date of Birth _____

NY State Public Health Law 2167 requires all post-secondary students enrolled in six or more credit hours to submit a "Meningococcal Disease Response Form". This law also requires all post-secondary institutions to distribute information about meningococcal disease and immunization to all students (or parents/guardians of students under the age of 18). There is no age differentiation regarding meningococcal disease.

This is NOT a required immunization, therefore, this requirement can be met by signing and dating the declination statement on the bottom of this form.

*[Note: The Advisory Committee on Immunization Practices recommends that all first-year college students up to age 21 years should have at least one dose of the meningococcal vaccine **not more than five years before enrollment**, preferably on or after their 16th birthday, and that young adults aged 16-23 years may choose to receive the meningococcal B vaccine series. College students should discuss the meningococcal B vaccine with a healthcare provider.]*

I / My child (for students under the age of 18) have:

- Had a meningococcal vaccination **within the last 5 years**. (check the choice that applies)
 - Documentation of this vaccination is attached to this form.
 - Administration of this vaccination has been validated by a health care provider as indicated below:

To be completed by a health care provider, NOT the student or student's parent/guardian

Date of Meningococcal Vaccination #1 _____

Date of Meningococcal Vaccination #2 _____

Type of Vaccination _____
(i.e., Menactra, Menveo, Menomune)

Type of Vaccination _____
(i.e., Menactra, Menveo, Menomune)

The above vaccination(s) have been validated by:

Health Care Provider name (printed) _____

Address _____
Street City State Zip

_____ Telephone Number

HCP's Signature _____

Date _____

The medical office's stamp validating this information can be used in lieu of the provider's signature.

MENINGOCOCCAL VACCINATION DECLINATION

I have read, or have had explained to me, information regarding meningococcal disease. I understand the risks of not receiving this vaccination, and have decided that I (my child) will **not** obtain immunization against meningococcal disease.

Student's Signature _____
(or parent if student is under 18 years of age)

Date _____

Please fax this completed form to 518-891-4236 or E-mail to healthrecords@nccc.edu