Triton College School of Continuing Education
Dialysis Technician Program Requirements

The following requirements are to be completed, reviewed by and turned in to the Health Services Department **within *30 days of the start of your 1st Clinical Course*.**

Triton College - Health Services
Location: Student Center (B -112)
Phone No: (708) 456-0300 x 3359
Hours: Monday - Friday from 8:00 a.m. to 4:00 p.m.

Requirements

1. **"School" Physical Exam -** within 30 days of clinical
2. **2 step Tuberculosis (TB) test** – within 30 days of clinical & kept current (see TB form)
3. **Rubella Titer (IGG)** – laboratory result
4. **Rubeola Titer (IGG)** – laboratory result
5. **Varicella Titer (IGG)** – laboratory result
6. **Mumps Titer (IGG)** – laboratory result
7. **Seasonal Influenza Vaccine**
8. **Confidential Medical History Form** – completed by the student
9. **Authorization for Release of Health Information Form -** completed by the student
10. **Indemnification and Release Form** – completed by the student
11. **Hepatitis B –** Titer or Waiver
12. **Tetanus, Diphtheria, and Pertussis (Tdap)**
13. **Hospitalization Insurance -** Health Insurance Card & kept current throughout program
14. **Health Care Provider CPR**
15. **Chart review** – 1:1 medical record review with a Triton College Health Services nurse
16. **Negative 5-Panel drug and alcohol screening**
17. **Felony and Misdemeanor Criminal Background Check showing "no findings"**
18. **HIPPA Compliance Information**
19. **Color Vision Testing**

Checklist

Checklist to be completed by a Triton College Health Services Nurse

Last Name First Name Middle Initial

Health Career Program Clinical Start Date

Dates are required for: Nuclear Medicine, D.M.S. and Radiology Technician.

_____ School Physical Exam

_____ 2 step Tuberculosis (TB) test – or – Equivalent
TB update – or – Equivalent due by: _____ & _____

_____ Rubella Titer (IGG)

_____ Rubeola Titer (IGG)

_____ Varicella Titer (IGG)

_____ Mumps Titer (IGG)

Vaccine Booster (circle): *MMR or Varicella: #1* _____ *#2* _____

_____ Seasonal Flu Vaccine
Seasonal *Flu Vaccine update done on:* _____ & _____

_____ Current CPR Card
CPR update due by: _____

_____ Confidential Medical History

_____ Authorization for Release of Health Information Form

_____ Indemnification and Release Form

_____ Hepatitis B - Titer or Waiver

_____ Tetanus, Diphtheria, and Pertussis (TDaP) - Injection or Waiver

_____ Hospitalization Insurance (Type): _____

_____ Negative 5-Panel drug & alcohol screening

_____ Felony & Misdemeanor Criminal Background Check showing "no findings"

_____ HIPPA Compliance

Reviewed by: _____ Date: _____
Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____
Student Copy: _____ Date: _____

Additional copies given to students are $10.00

School Physical Examination

To be completed within 30 days of the start of your 1st Clinical Course

_____

Last Name **First Name** **Middle Initial**

	Normal	Abnormal	Comments
1. General Appearance			
2. Skin			
3. Eyes			
4. Ears/Nose/Throat			
5. Hearing			
6. Lymph Nodes			
7. Respiratory			
8. Cardiovascular			
Blood Pressure			
Pulse			
9. Abdomen/G.I.			
10. Musculoskeletal			
11. Joints/Extremities			
12. Neurological			
13. Metabolic/Endocrine			
14. Other			

Is the student receiving medication or treatment for any health-related problems that may impair his/her ability to perform their clinical duties safely?
Yes_____ No_____ If Yes; list and indicate if the student may/may not perform clinical duties with/without restriction or limitation.

_____

_____

Does the student have restrictions or limitations in performing their clinical duties safely?
Yes_____ No_____ If Yes; list and indicate if the student may/may not perform clinical duties with/without restriction or limitation.

_____

_____

Physician Signature: _____ Date: _____

Health Care Provider Stamp

2 - Step Tuberculosis Test

To be completed within 30 days of the start of your 1st Clinical Course

_____

Last Name **First Name** **Middle Initial**

The First TB Test is given and read by the same health care facility of your choice within 48-72 hours.

The Second TB Test is to be completed within 7 to 21 days from the First TB Test. It is given and read by the same health care facility of your choice within 48-72 hours.

The TB test must be **"kept current"** throughout your program; meaning a 1-step TB update test must be done within 365 days of your last TB test or as recommended by the clinical site.

Have you ever had a positive TB test? **Yes ___ No ___**

Have you ever had a BCG injection? **Yes ___ No ___**

TB step 1:
Date Given: _____ Time Given _____ Lot No. _____ R. /L. Forearm Nurse: _____

Date Read: _____ Time Read _____Results _____ Nurse: _____

TB step 2:
Date Given: _____ Time Given _____ Lot No. _____ R. /L. Forearm Nurse: _____

Date Read: _____ Time Read _____Results _____ Nurse: _____

TB Update:
Date Given: _____ Time Given _____ Lot No. _____ R. /L. Forearm Nurse: _____

Date Read: _____ Time Read _____Results _____ Nurse: _____

* Other/Equivalent*

Chest X-Ray or Quantiferon Gold Blood Test: Attach Laboratory Results to Chart

TB Test & Live Vaccine's

If you are in need of a **LIVE VACCINE; IT MUST NOT BE ADMINISTERD ON THE SAME DAY AS THE 1st TB INJECTION**, as it may cause a false negative TB result. Live Vaccines may be given "with" the 2nd TB test injection. Examples of live vaccine's are:

- MMR (measles, mumps and rubella)
- Attenuvax (rubeola)

- Varivax (varicella)
- Pneumovax (pneumonia)

Health Care Provider Stamp

Authorization for Release and/or Exchange of Health Information

I, _____, authorize Triton College's Health Services Department to release and/or exchange the following information about me (check one):

☐ Any information in my health services record.
☐ Other (please specify) _____
_____

Person or agency with which Triton College Health Services may exchange information:

☐ Person/Agency: Triton College/Clinical Sites/CCMSI
☐ Other: _____

THIS CONSENT IS VALID UNTIL (check one):

☐ The completion of my academic career at Triton College
☐ Specific date_____/_____/_____

I understand that I may revoke this consent at any time and that the above named person/agency with which Health Services is authorized to exchange information has the right to inspect or copy the information to be disclosed.

It has been explained to me and I understand that if I refuse to consent to this release of information, the Triton College Health Services staff's ability to assist me may be hindered.

By signing this release, I further agree to hold harmless and indemnify Triton College, its officers, agents, trustees and employees against any losses, damages, judgments, claims, expenses, costs and liabilities imposed upon or incurred by or asserted against Triton College, its officers, agents, trustees or employees, including reasonable attorneys' fees and expenses, arising out of a release of health information consistent with this Release Form.

Student Signature Date

Witness signature Date

NOTE TO PERSON/AGENCY EXCHANGING INFORMATION; under the provisions of the Illinois Mental Health and Development Disabilities Confidentiality Act you may not re-disclose any of this information unless the above signed client specifically consents to such disclosure. Under the Federal Act of July 1, 1975, confidentiality of alcohol and drug abuse patient records, no such records or information from such records may be further disclosed without specific authorization for such re-disclosure.

Indemnification and Release Form

I, _____, agree to hold harmless and indemnify Triton College, its officers, agents, trustees and employees against any losses, damages, judgments, claims, injuries, expenses, costs and liabilities imposed upon or incurred by or asserted against Triton College, its officers, agents, trustees or employees, including reasonable attorneys' fees and expenses, arising out of my acts or omissions while participating in my clinical rotation as a part of my educational program at Triton College.

I fully release Triton College and shall assume all such costs, losses, damages, injuries, claims, demands and expenses of any lawsuit, legal proceeding, defense or settlement. Additionally, I shall pay all judgments entered in any such suit or other legal proceedings.

My obligations under this indemnity and release form shall continue and remain in full force and effect beyond the conclusion of the clinical rotation and Triton College's academic year.

Student Signature Date

Witness signature Date

Hepatitis B - Release of Liability

Those who cannot show proof of an "Immune" Hepatitis B Titer must sign this waiver.

According to the Center for Disease Control (2003) Hepatitis B is caused by a virus that attacks the liver. The virus, which is called hepatitis B virus (HBV), can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure, and death.

In 2003, an estimated 73,000 people were infected with HBV. People of all ages get hepatitis B and about 5,000 die per year of sickness caused by HBV.

HBV is spread when blood from an infected person enters the body of a person who is not infected. Healthcare personnel who have received hepatitis B vaccine and developed immunity to the virus are at virtually no risk for infection.

Retrieved From: http://www.cdc.gov/ncidod/dhqp/bp_hepatitisb.html

* *

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. Hepatitis B Virus infection is a serious health problem which affects many health care providers and can lead to lengthy illness, hospitalization, and possibly, an untimely death.

I have also been informed of the benefits of Hepatitis B Vaccine, the side effects of Hepatitis B Vaccine, and also of the modes of transmission of HBV.

Although required by the health program in which I am enrolled, I decline the Hepatitis B vaccination at this time. I understand by declining this vaccine I continue to be a risk of contracting Hepatitis B.

I personally assume the risks and consequences of my refusal, and I release for myself, my heirs, executors, administrator, or personal representatives Triton College, its officers, agents and employees from any and all liability for ill effects, including death or disability, which may result from contracting Hepatitis B virus infection.

I acknowledge that I have been thoroughly informed and I understand the implications of declining the Hepatitis B vaccine.

_____

Student Signature Date

Tetanus/Diphtheria/Pertussis (TDaP) – Release of Liability

Those who cannot show proof of TDaP Vaccination within the last 8 years must sign this waiver.

The American College Health Association and the Center for Disease Control and Prevention (CDC), recommends that institutions that train health care professionals, deliver healthcare, or provide laboratory or other medical support services require students to be vaccinated against Tetanus, Diphtheria, and Pertussis (TDaP).

The Tetanus, Diphtheria, and Pertussis (TDaP) Vaccine can protect you against all three of these serious diseases.

Tetanus, diphtheria, and Pertussis are all caused by bacteria. Diphtheria and Pertussis are spread from person to person. Tetanus enters the body through cuts, scratches, or wounds.

Tetanus (Lockjaw) causes painful tightening of the muscles, usually all over the body. It can lead to "locking" of the jaw so the victim cannot open his mouth or swallow. Tetanus leads to death in up to 2 cases out of 10.

Diptheria causes a thick covering in the back of the throat. It can lead to breathing problems, paralysis, heart failure, and even death.

Pertussis (Whooping Cough) causes severe coughing spells, vomiting, and disturbed sleep. It can lead to weight loss, incontinence, rib fractures and passing out from violent coughing, pneumonia, and hospitalization due to complications.

* *

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring the Tetanus, Diphtheria, and Pertussis infections.

I have been informed of the benefits of the TDaP vaccine, the side effects of the vaccine, and the modes of transmission of Tetanus, Diptheria and Pertussis.

Although required by the health program in which I am enrolled, I decline the TDaP vaccination at this time. I understand by declining this vaccine, I continue to be a risk of acquiring the Tetanus, Diphtheria, and Pertussis infections.

I personally assume the risks and consequences of my refusal, and I release for myself, my heirs, executors, administrator, or personal representatives Triton College, its officers,

agents and employees from any and all liability for ill effects, including death or disability, which may result from contracting the Tetanus, Diphtheria, and Pertussis infections.

I acknowledge that I have been thoroughly informed and I understand the implications of declining the TDaP vaccine.

Student Signature Date

Triton College - Confidential Medical History

Have you had/ Do you have	Yes	No		Yes	No		Yes	No		Yes	No
Rheumatic Fever			Lung Disease			Stomach Problems			Back Problems		
Scarlet Fever			Tuberculosis			Bowel/Colon Problems			Knee Problems		
Mumps			Asthma			Recent weight Gain			Ankle/Foot Problems		
Rubella (German Measles)			Chronic Cough			Recent weight Loss			Wrist Problems		
Rubeola (Measles)			Hay fever			Seizures/Epilepsy			Elbow Problems		
Varicella (Chicken Pox)			Sinus Problems			Dizziness			Shoulder Problems		
Epilepsy			Seasonal Allergies			Fainting			Arthritis		
Head Injury			Heart Disease			Depression			Weakness		
Stroke			High Blood Pressure			Anxiety			Paralysis		
Migraine			Low Blood Pressure			Insomnia			S.T.D.'s		
Gallbladder Problems			Pain/Pressure in Chest			Mental Illness			Surgery		
Liver Disease			Heart Palpitations			Eye Problems			Cancer/Tumor		
Hepatitis			Kidney Disease			Ear Problems			Food/Rx Allergies		
Jaundice			Frequent Urination			Nose Problems					
Pancreatitis			Bone Problems			Throat Problems			Other		
Diabetes			Joint Problems			Gum/Teeth Problems					

If you have answered yes to any of the above please explain on a separate sheet of paper

1. Which diagnosis you had/have?
2. When you were diagnosed with the medical condition?
3. List any treatment you had or are currently undergoing for the medical condition.

_____

Signature **Date**

Revised: 05/12

Triton College - Confidential Medical History

_____

Last Name First Name Middle Initial Health Career Program

_____

Address City State Zip Code

Date of Birth_____ Height_____ Weight_____ Drug Allergies_____Phone_____

In case of an Emergency please notify: _____Relationship_____Phone_____

Are you physically, emotionally and mentally able to perform all the duties required of you as a student assigned to patients and multiple participating health care settings without accommodations? Yes No

If No; provide a statement from your M.D. stating if you are able/unable to perform all functions necessary to fulfill your clinical rotations in a safe manner with/without restrictions or limitations.

If you require accommodations, please list what these consist of: _____

Medications you are currently taking: _____

Are you Pregnant? Yes No N/A

If Yes; provide a statement from your M.D. stating if you are able/unable to perform all functions necessary to fulfill your clinical rotations in a safe manner with/without restrictions or limitations.

I am aware of the physical, emotional and mental requirements of the allied health program in which I am enrolled and certify that my confidential medical history given to both Triton College and my Medical Doctor is both current and accurate. I understand that any false answers or statements made by me in this application will be grounds for immediate dismissal from my enrollment in the Health Career program in which I am enrolled.

_____

Signature **Date**

Revised: 05/12

Health Requirement Information

TB Test & Live Vaccine's

If you are in need of a **LIVE VACCINE; IT MUST NOT BE ADMINISTERD ON THE SAME DAY AS THE 1st TB INJECTION**, as it may cause a false negative TB result. Live Vaccines may be given "with" the 2nd TB test injection. Examples of live vaccine's are:

- MMR (measles, mumps and rubella)
- Attenuvax (rubeola)
- Varivax (varicella)
- Pneumovax (pneumonia)

TB test administered with a Live Vaccine

If a live vaccine is given with the 1st step TB injection; it will be necessary to re-administer the 2 step TB test after waiting a 4-6 week time span after the live vaccination administration. If this sequence of events occurs; it will cause a delay in the start of your clinical rotation. If you are unable to wait 4-6 weeks to re-start the 2 step TB process - a negative chest x-ray or a negative Quantiferon Gold blood test will suffice.

Titers

Titers are lab results that confirm the presence of adequate protection against viruses such as the Measles, Mumps, Rubella, Varicella and the Hepatitis B viruses found in your blood. The presence of IgG antibodies (Not IgM antibodies) indicates a history of past exposure to the virus or vaccination. A positive IgG result indicates that the person tested should be immune to the virus. Titers are valid for your lifetime. If your titers were drawn previously i.e.; previous health career program, job or prenatal care; we will accept these.

Live Vaccine's

If your Blood Titers (Measles, Mumps, Rubella or Varicella) are either "negative" or "equivocal" you must receive 2 "booster vaccines" 6-8 weeks apart. Students in need of 2 boosters may start their clinical rotation with evidence of one of the two live vaccines needed. The 2 vaccine boosters are recommended for Healthcare Personnel by the CDC; visit: http://www.immunize.org/catg.d/p2017.pdf for more information.

Physicals

You are required to have a "school physical" which is less comprehensive than a traditional "adult physical". School Physicals are valid for 2 years, while in the same health career program.

Hospitalization Insurance

You are responsible for continuous health and hospitalization insurance coverage during your enrollment in the program. If your insurance information changes; bring your new identification card to the Health Services department.

Pregnant Student's

All pregnant students need a physicians note stating that they are pregnant and may perform their clinical rotations without restrictions.

Student's with Health or Mental Conditions

Students with special health or mental conditions need a physician's note stating their diagnosis for any condition which may pose a health/safety threat. The note must also state that you are able to perform your clinical rotations without restrictions.

Examples of special health or mental conditions are: Lifting Restrictions, Weight Bearing Restrictions, Range of Motion Limitations, Loss of Consciousness, Epilepsy, IDDM, Seizure Disorder, Hepatitis A, B or C positive antigen, Tuberculosis positive antigen, HIV, AIDS or any other condition which may interfere with your clinical rotations.

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Healthcare Resources

TB

Cook County Department of Public Health's TB Clinic
7556 W. Jackson Blvd. Forest Park, IL
Available by Appointment Only - Phone: 708-836-8600

TB Tests are conducted on Monday's & Friday's only - Free
Quantiferon Gold Testing: Conducted at this location
X-Ray's: Not conducted at this Location

Drug Testing

10 Panel Drug Test & Breathalyzer

Clinic	Location	Phone	Cost
WorkPlus	7230 w. North Ave. Elmwood Park	708-453-3000	$56
Loyola	1211 W. Roosevelt Rd. Maywood	708-531-7900	$70
Alexian Brothers	800 Biesterfield Rd. Elk Grove Village	847-981-5910	$57
Alexian Brothers	1240 North Busse Rd. Bensenville	847-228-6407	$57
AOMS	4200 N. Mannheim Rd. Schiller Park	847-801-5170	$70
Advocate	Downers Grove/Niles/Elk Grove Village	See location	$65
First Aid Clinic	7742 W. Higgins Rd. Chicago	773-775-6200	$70

Physical/TB/Titers/Vaccines/Drug Test/Flu

Advanced Occupational Medicine Specialists (AOMS)
4200 N. Mannheim Rd. Schiller Park, IL 60176
Phone: 847-801-5170 - Lab Draw Fee = $10.00

Physical	$30	**Vaccines**		**TB or Equivalent**	
Titers		MMR	$75	TB Test	$15
Rubeola	$35	Rubella		Quantiferon Gold	$100
Mumps	$35	Varicella	$95	CXR	$40
Rubella	$35	TD	$50	**Drug Testing**	
Varicella	$35	Hepatitis B	$55	10 Panel & Breathalyzer	$70
Hepatitis B	$50	Seasonal Flu	$25		

Physical/TB/Titers/Vaccines

Advocate Occupational Health
3551 Highland Avenue Suite 200 Downers Grove, IL 630-275-2900
or
7255 N. Caldwell Niles, IL 847-647-0355
or
1502 S. Elmhurst Rd. Elk Grove Village, IL 847-228-0515
$10.00 Lab Draw Fee

Physical	$30	**Vaccines**		**TB or Equivalent**	
Titers		MMR	$70	TB Test	$15
Rubeola	$45	Rubella		Quantiferon Gold	$85
Mumps	$45	Varicella	$94	CXR	$70
Rubella	$25	TDaP	$50	**Drug Testing**	
Varicella	$35	Hepatitis B	$61	10 Panel & Breathalyzer	$65
Hepatitis B	$50	Seasonal Flu	$25		

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Physical/TB/Titers/Vaccines/Flu

First Aid Clinic
7742 W. Higgins Rd. Suite C-102, Chicago, IL. 60631
773-775-6200
Titer prices are dependent upon receiving a Physical

Physical	$30	**Vaccines**		**TB or Equivalent**	
Titers		MMR	$70	TB Test	$25
Rubeola	$12	Rubella		Quantiferon Gold	
Mumps	$12	Varicella	$110	CXR	$50
Rubella	$12	TDaP	$80	**Drug Testing**	
Varicella	$12	Hepatitis B	$55	10 Panel & Breathalyzer	$70
Hepatitis B		Seasonal Flu	$20		

Physical/TB/ Vaccines/Flu

Walgreens - Take Care Health Clinic
Central Phone: 866-825-3227

Physical	$60	**Vaccines**		**TB or Equivalent**	
Titers		MMR	$96	TB Test	$28
Rubeola		Rubella		Quantiferon Gold	
Mumps		Varicella	$146	CXR	
Rubella		TDaP	$64	**Drug Testing**	
Varicella		Hepatitis B	$100	10 Panel & Breathalyzer	
Hepatitis B		Seasonal Flu	$32		

Physical/TB/ Vaccines/Flu

CVS Pharmacy – Minute Clinic
Central Phone: 866-389-2727

Physical	$59	**Vaccines**		**TB or Equivalent**	
Titers		MMR	$116	TB Test	$39
Rubeola		Rubella		Quantiferon Gold	
Mumps		Varicella		CXR	
Rubella		TDaP	$79	**Drug Testing**	
Varicella		Hepatitis B	$102	10 Panel & Breathalyzer	
Hepatitis B		Seasonal Flu	$30		

Titers

Uni-Lab
418 N. Austin # 2 A. Oak Park, IL. 60302 Phone: 708-848-1556 - Lab Draw Fee = $10.00

Physical		**Vaccines**		**TB or Equivalent**	
Titers		MMR		TB Test	
Rubeola	$15	Rubella		Quantiferon Gold	
Mumps	$15	Varicella		CXR	
Rubella	$10	TDaP		**Drug Testing**	
Varicella	$20	Hepatitis B		10 Panel & Breathalyzer	$25
Hepatitis B	$15	Seasonal Flu			

Hospitalization Insurance

First Agency, Inc.
5071 West H Ave. Kalamazoo, MI. 49009
(269) 381-6630 – http://www.1stagency.com

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CPR Resources

Acceptable Card: Health Care Provider CPR Card
*****Online CPR courses will NOT be accepted*****

Name	Address	Phone	Cost
American Heart Association	Triton College Instructor: Margie Harp	708-456-0300 x 3489 x 3773	$67
American Heart Association	http://www.americanheart.org/cpr	877-242-4277	$67
American Red Cross	3302 W. 87th St. Chicago, IL 60652 http://www.chicagoredcross.org	773-238-3057	$125
Chicago CPR Now	3701 N. Ravenswood Suite206, Chicago, IL. 60613 www.chicagocprnow.com	773-981-2772	$55
CPR Associates, Inc.	2616 W. Peterson Ave. Chicago, IL 60659 www.cprassociatesinc.com	773-973-6933	$35
CPR Associates, Inc.	7240 W Foster Ave, Chicago, IL 60656 www.cprassociatesinc.com	773 - 467-1300	$35
Enjoy CPR	www.EnjoyCPR.com/Chicago	312-235-1061	$50
Multi-Hazard	120 S. State St.Chicago, IL. 60603 www.multi-hazard.org	773-525-7430	$65