# STUDENT HEALTH SCREENING

Students in the Radiography Program at Regional West must be in good health to provide quality health care to patients in clinical situations. To assure that students are in good physical health, a health screening and an immunization record are required. Each student will assume responsibility for managing his or her own health care, health care expenses, and for meeting health requirements.

Responsibility: Program Director, Medical Advisor, Students
Standard: Human Resources

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## PURPOSE

The purpose of the health screening is to ensure a safe and healthy environment for the employees, patients, other students and hospital visitors.

Each student is required to complete the Student Information Form to provide contact information and other general health information in the event of student illness or injury. Changes in the students' contact information should be immediately reported to the Program. An Update of Student Contact Information Form is attached.

### Health Screening

New students will receive a Health Screening as part of the enrollment process

New students under the age of 19 need the Parent/Guardian Consent for Employment Health Screening Form (8373.010) signed by a parent or legal guardian at the time of the health screening.

The health screening will include:

1. A drug test;
2. Assessment or check of blood pressure, weight, and height (as appropriate);
3. Blood draw for required tests (Rubeola, Rubella, Mumps, Varicella, Hepatitis B antibody) and Purified Protein Derivative (PPD)test or Quantiferon Gold TB lab test (as appropriate) or chest x-ray;
4. Latex exposure history;
5. Occupational Safety and Health Administration (OSHA) respiratory protection medical evaluation questionnaire (as appropriate) and as required by 29 CFR 1910.134.
6. Audiometric testing, as appropriate, as required by OSHA (29 CFR 1910.95).
7. Color perception screening, as appropriate.
8. Snelling eye exam and laser eye exam, as appropriate.
9. Vaccinations which may include Covid-19, Influenza, Measles Mumps

Rubella (MMR), Tetanus Diphtheria Pertussis (Tdap), Varicella, and HepatitisB11.*

10. Respirator Fit testing as appropriate

*Vaccinations are mandatory. Exemptions will be granted per sponsoring institution policy (see below)

- Mandatory COVID-19 Vaccination, policy 206.0.15
- Employee Influenza Vaccination Program, policy 206.0.03
- Employee Varicella Vaccination Program, policy 206.0.10
- Employee Measles, Mumps and Rubella (MMR) Vaccination Program, policy 206.0.12
- Employee Tetanus, Diphtheria and Acellular Pertussis (TDAP) Vaccination Program, policy 206.0.13

The services described above will be provided by Regional West Medical Center or Western Pathology Consultants, Inc at no additional cost to the student. Screening beyond these services is the responsibility of the student, either by his or her personal health plan or self-pay. These services will be provided for the student only - not for any of his or her dependents.

**VACCINATION RECORD**

A current vaccination record should be submitted to the Program before the first week of classes. This current record must come from a state department of health (i.e. Nebraska State Immunization Information System) or a Licensed Independent Practitioner. If coming from a Licensed Independent Practitioner, the date of immunizations or immunity and his or her signature must be included

**HEALTH**

Each student will assume responsibility for managing his or her own health care, health care expenses, and for meeting health requirements

**STUDENT HEALTH RECORDS**

Student health records shall be maintained by the Program Director and Occupational Health Department and shall become a part of the student's permanent record.

All information in the student's health record is confidential. Latex allergy, influenza vaccine and hepatitis immune status may be released to the Infection Control nurse or student's clinical supervisor on a need-to-know basis. Other information from a student's health record will be released only within the context of legal demands from insurance or regulatory agencies. Off-campus clinical sites may require documentation of medical information for that facility's records.

Information will be released only with written permission from the student and only to those persons or agencies specified in the written request.

Digitally signed by Stephanie Cannon
Date: 2023.07.20 15:57:00 -06'00'

Signature
Stephanie Cannon, MSRS, RT(R)(ARRT)
Program Director

Joshua Lively
Digitally signed by Joshua Lively
Date: 2023.08.10 05:20:09 -06'00'

Signature
Joshua Lively, MHA, BSRT(R), RT (R)(VI)(ARRT)
Director of Imaging Services

Reference: Hospital Policy 206.0.01

Reviewed: 7/31/0, 3/26/03, 6/28/06, 3/29/12, 4/18/13, 3/4/16, 1/27/17, 4/27/20, 9/30/21, 3/31/2023
Revised: 09/22/88, 04/09/91, 7/16/94, 5/12/95, 6/14/96, 12/29/99, 8/19/00, 1/11/01, 6/26/01, 5/31/04, 1/9/08, 5/10/08, 8/6/10, 11/1/11, 3/29/12, 2/21/2014, 2/6/15, 2/2/18, 1/31/19

# PHYSICIAN VARICELLA VACCINATION EXEMPTION LETTER

Date_____

Regional West Health Services
4021 Avenue B
Scottsbluff, NE 69361

Attention: Safety and Occupational Health Office

Student's Name_____

**The above student is unable to receive the Varicella vaccination due to the following**

1. **Permanent Exemptions**
   - ____ Anaphylactic (life-threatening) allergy to gelatin or neomycin.
   - ____ Anaphylactic (life-threatening) reaction to a previous Varicella vaccination.
   - ____ Chronic steroid use longer than 2 weeks for persons who are immunocompromised or receiving >20 mg/day of prednisone or equivalent.
   - ____ Immunodeficiency (for example, cancer or cancer treatment, HIV/AIDS, untreated active tuberculosis).

2. **Temporary Exemptions** (expected date temporary exemption will end_____)
   - ____ Current use of antiviral drugs (for example, acyclovir or valacyclovir) (discontinue use ≥24 hours before administration of Varicella vaccination).
   - ____ IG (Immune Globulin), blood, or plasma transfusions (wait 3-11 months before administration of Varicella vaccination).
   - ____ Pregnancy (women should not become pregnant within 4 weeks of Varicella vaccination)
   - ____ Moderate or severe illnesses, with or without fever, at the time the Varicella vaccination is scheduled.
   - ____ Temporary steroid use longer than 2 weeks for persons who are immunocompromised or receiving >20 mg/day of prednisone or equivalent.
   - ____ Immunodeficiency (for example, cancer or cancer treatment, HIV/AIDS, untreated active tuberculosis).

Provider Name (please print) _____

Provider Signature _____

Please release the requested information regarding my ability to receive a Varicella vaccination to Regional West Health Services Safety and Occupational Health Department.

_____ _____

Signature of student Date

**Note:** Please return completed form to RWHS Safety and Occupational Health Office or fax to 630-1180.

Date _____

Regional West Health Services
4021 Avenue B
Scottsbluff, NE 69361

Attention: Safety and Occupational Health Office

Student's Name _____

The above student is unable to receive the inactivated flu vaccination secondary to the following

____ An anaphylactic (life-threatening) reaction to any component of the specific vaccine (if known, list component_____)
____ Guillain-Barre Syndrome (a severe paralytic illness)

If the above criteria are not met, identify which vaccine the employee should receive:
Recombinant Hemagglutinin Influenza Vaccine (RIV3; FluBlok) _____
Cell Culture-based Inactivated Influenza Vaccine (ccIIV3; Flucelvax) _____
Inactivated Influenza Vaccine (Standard) _____

Provider Name (please print) _____

Provider Signature _____

Please release the requested information regarding my ability to receive an influenza vaccination to Regional West Health Services Occupational Health nurses.

_____ _____
Signature of student Date

**Note –** Please return completed form to RWHS Safety and Occupational Health office or fax to 308-630-1180.

# CONTRACT PERSONNEL/STUDENT/VOLUNTEER REQUIREMENTS

**Name**_____ **Department** _____
**Start date**_____ **End Date**_____ **DOB** _____

**Urine Drug Test**
(Contract personnel only—no more than 30 days prior to start of assignment) _____

**Current/annual respirator fit test** (contract personnel only; within last 12 months; models KC46767, KC46867, 3M1860, 3M1860S, 3M1870 PLUS, PAPR type) _____

**Record of Varicella IgG Positive/Negative**_____
If negative, record of two doses of vaccine #1 _____ #2 _____
Then re-titer _____

Or signed Regional West Health Services exemption letter _____

**Record of Hepatitis B antibody Positive/Negative** _____
If negative, record of 3 doses of vaccine #1 _____ #2 _____ #3 _____

Then re-titer_____ If still negative, record of booster #4 _____
Then re-titer_____ If still negative, record of 2 more doses #5_____ #6 _____
Then re-titer _____ If still negative, non-converter

Or declination signed _____

**Record of Measles IgG Positive/Negative**_____
If negative, record of two doses of vaccine #1_____#2 _____
Then re-titer_____If still negative, record of booster #3 _____
Then re-titer_____If still negative, non-converter
Or signed Regional West Health Services exemption letter _____

**Record of Mumps IgG Positive/Negative**_____
If negative, record of two doses of vaccine #1_____#2 _____
Then re-titer_____If still negative, record of booster #3 _____
Then re-titer_____If still negative, non-converter
Or signed Regional West Health Services exemption letter _____

**Record of Rubella IgG Positive/Negative** _____
If negative, record of one dose of vaccine #1 _____
Then re-titer_____If still negative, record of booster #2 _____
Then re-titer_____If still negative, non-converter
Or signed Regional West Health Services exemption letter _____

**Record of Flu vaccination during flu season (usually August through May)**_____
Or signed Regional West Health Services exemption letter _____

**Record of Tuberculosis (TB) testing**
TB skin test within last 12 weeks (90 days)_____ **and** within last 12 months _____
OR Quantiferon Gold TB lab test within last 12 weeks _____
If + TB testing, record of negative chest x-ray _____

**Record of tetanus, diphtheria, and pertussis (Tdap) vaccination** _____
Or signed Regional West Health Services exemption letter _____

**(COPIES OF DOCUMENTS MUST BE ATTACHED TO QUALIFY)**

**Covid-19 Vaccine** _____ _____ _____
OR Covid-19 exemption _____



Regional West Health Services
308.635.3711 | 4021 Avenue B | Scottsbluff, NE 69361

# REGIONAL WEST HEALTH SERVICES
# REQUEST FOR MEDICAL EXEMPTION TO THE COVID-19 VACCINATION REQUIRMENT

Signing this form constitutes a declaration that the information you provide is true and correct to the best of your knowledge and ability. Any intentional misrepresentation may result in legal consequences, including termination or removal from employment / job function. Information contained on this form will be kept in strict confidence and shared only when required by law and regulation.

To request a medical exemption or delay from the COVID-19 vaccination requirement using this form:
1. You must complete Part 1 of this form.
2. Your medical provider must complete Part 2 of this form.
3. When both are completed, submit to Occupational Health (Fax 308-630-1180 OR OccupationalHealth@rwhs.org)

| **Part 1 – To Be Completed by the Individual Seeking Exemption** | | |
|---|---|---|
| **Name** | **Date of Birth** | **Date of Request** |
| | | |
| **Department** | | **Division** |
| | | |
| **Position** | **Supervisor** | **Phone Number** |
| | | |

**Medical or Disability Exemption Request**

I am requesting a medical exemption to the requirement for COVID-19 vaccination or a delay because of a temporary condition or medical circumstance. I am requesting a medical exemption from administration of the following vaccines:

- BioNTech, Pfizer Vaccine
- Johnson & Johnson Vaccine
- Moderna NIAID Vaccine
- A vaccine listed by the World Health Organization (WHO) for emergency use that is not approved or authorized by the FDA, or a vaccine that is administered in a clinical trial.

| **Signature** | |
|---|---|
| | |
| **Print Name** | **Date** |
| | |


 


Regional West Health Services
308.635.3711 | 4021 Avenue B | Scottsbluff, NE 69361

**Part 2 – To be Completed by the Medical Provider**

| **Individual's Name** |
|---|
| |

**Medical Certification for COVID-19 Vaccine Exemption**

Dear Medical Provider:

The individual named above is seeking a medical exemption to the requirement for COVID-19 vaccination or a delay because of a temporary condition or medical circumstance. Please complete this form to assist in a reasonable accommodation process. If you have questions about completing this form, please contact the RWHS Occupational Health Department (308-630-1151 or OccupationalHealth@rwhs.org)

Please provide at least the following information, where applicable:

1. The applicable contraindication or precaution for COVID-19 vaccination
2. A statement that the individual's condition, and medical circumstances relating to the individual, are such that COVID-19 vaccination is not considered safe, indicating the specific nature of the medical condition or circumstances that contraindicate immunization with a COVID-19 vaccine or might increase the risk for a serious adverse reaction; and
3. Any other medical condition that would limit the employee from receiving any COVID-19 vaccine.

**Description of the medical condition for which the employee listed above should be exempt from complying with a COVID-19 vaccination requirement:**

__ Received monoclonal antibody infusion or convalescent plasma for Covid-19 w/in last 90 Days (Date_)
__ Current confirmed Covid-19 infection; individual still in isolation (Date of Pos Test_____)
__ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine
__ Immediate (w/in 4 hrs of exposure) allergic reaction of any severity to a previous dose
__ Known (diagnosed) allergy to a component of the vaccine
__ Occurrence of myocarditis or pericarditis after a dose of an mRNA COVID-19 vaccine
__ Contraindication/Physician Recommendation (Please attach note or comments below from provider)

Comments:

| **The condition described above is:** | ☐ temporary | ☐ long-term |
|---|---|---|

If this is a temporary condition or medical circumstance, when it is expected to end or expire (allowing for COVID-19 vaccination to begin after the date you provided):

| **Medical Provider Name/Title** | |
|---|---|
| | |
| **Medical Provider Signature** | **Date** |
| | |

****Submit request form and any additional documentation by fax to 308-630-1180 or e-mail OccupationalHealth@rwhs****

Vaccine Review Committee Determination: Approved Denied/Referred to Review Committee Hearing Date:_____Signature: _____




Regional West Health Services
308.635.3711 | 4021 Avenue B | Scottsbluff, NE 69361

## REGIONAL WEST HEALTH SERVICES
## REQUEST FOR RELIGIOUS EXEMPTION TO THE COVID-19 VACCINATION REQUIRMENT

A religious exemption may be granted if (i) the individual holds sincere religious beliefs which are contrary to the practice of vaccination, (ii) completes this form, and (iii) provides required documentation to support the request.

Signing this form constitutes a declaration that the information you provide is true and correct to the best of your knowledge and ability. Information contained on this form will be kept in strict confidence and shared only when required by law and regulation.

| Name | Date of Birth | Date of Request |
|---|---|---|
| | | |

| Department | Division |
|---|---|
| | |

| Position | Supervisor | Phone Number |
|---|---|---|
| | | |

**Exemption Request**

In the space below, please provide a personal written and signed statement detailing the religious basis for your vaccination objection, explaining why you are requesting this religious exemption, the religious principle(s) that guide your objections to vaccination, and the religious basis that prohibits the COVID-19 vaccination. Please attach additional documentation, if necessary.

**Attestation Statement**

By my signature below I attest to the following:

1. I request exemption from the designated vaccination requirement due to my sincere religious beliefs. I understand and assume the risks of non-vaccination. I accept full responsibility for my health, thus holding harmless and removing from any liability Regional West Health Services (RWHS).
2. I understand that as I am not vaccinated, in order to protect my own health and the health of the community, I will comply with assigned COVID-19 testing requirements and other preventive guidance.
3. I understand and agree to comply with and abide by all Regional West Health Services COVID-19 policies and procedures.
4. I understand that, if approved, this exemption is provisional based on the current Regional West Health Services COVID19 vaccination policy and is subject to change moving forward.
5. I certify that the information I have provided in connection with this request is accurate and complete as of the date of submission.

**Signature**

| Print Name | Date |
|---|---|
| | |

****Submit request form and any additional documentation by fax to 308-630-1180 or e-mail OccupationalHealth@rwhs****

Vaccine Review Committee Determination: □ Approved □ Denied/Referred to Review Committee Hearing Date:_____Signature: _____




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