HORRY GEORGETOWN TECHNICAL COLLEGE

Health Tracker Clinical Requirements

for

Computerized Axial Tomography
Diagnostic Medical Sonography
Health Care Certificate
Medical Laboratory Technology
Nursing
Occupational Therapy Assistant
Paramedic
Patient Care Medical Assistant
Phlebotomy
Physical Therapy Assistant
Radiologic Technology
Respiratory Care
Surgical Technology
Vascular Sonography

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All boxes must be checked on page 1 and 2. Be sure you sign and date page 2.
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Clinical Requirements Checklist*

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- [ ] Urine Drug Screening – *see CBC/UDS/HT Instructional Packet*
- [ ] Castle Branch Compliance Tracker – *see CBC/UDS/HT Instructional Packet*
- [ ] GHO Care Learning Modules Transcript
- [ ] BLS CPR Certification
- [ ] Health Physical completed on HGTC 4-page forms.
- [ ] 2 Step PPD or QFT Gold Blood Assay
- [ ] Seasonal Flu Vaccine (not required for the summer semester)
- [ ] COVID Vaccine Card if you have one or answer No in your CB Tracker.
- [ ] Tdap Vaccine
- [ ] Hepatitis B 3- or 2- dose series or + Titer or Declination Waiver
- [ ] MMR 2 doses or + Titer Lab Results showing your scores with the reference ranges.
- [ ] Varicella 2 doses or + Titer Lab Results showing your score with the reference range.
- [ ] Liability Insurance Certificate
- [ ] Clinical Forms and Disclosures
- [ ] Photo to be taken in the Clinical Admissions Office, Speir Bldg., room 1209

*This checklist is for all Nursing and Health Science Students except Dental Hygiene, Dental Assisting, EMT Basic and Massage Therapy.

IMPORTANT NOTES

- Any requirement that will expire mid semester must be completed before the semester begins. Example, your CPR certificate expires in March or your QFT expires in April, you must renew these before classes start in January.
- **CPR Certification** – there are many different types of CPR Certification. **BLS (Basic Life Support) for HealthCare Providers through AHA or ARC ONLY is the certification that is required.**
- One year from the date of your physical, a **physical waiver** may be submitted annually ONLY if there has been no change in your health status.
- **2 Step PPD or QFT Gold Blood Assay**
  - A 2 Step PPD is two (2) Tuberculin skin tests. You will visit the physicians/clinics office four (4) times. You have step one administered and then read 48-72 hours later. Seven (7) days later after step one is read, you then have step two administered. Step two is then read 48-72 hours later. There is a max timeframe of 21 days (3 weeks) between Step 1 and Step 2.
  - You may have a QFT Gold Blood Assay in lieu of the traditional skin tests (2 Step PPD). This is a blood draw to test for tuberculosis.
  - After the initial 2 Step PPD or QFT, you will be required to receive a 1 step PPD or QFT Gold Blood Assay yearly. Do not let time lapse or you will need to complete the 2 Step PPD again. Example: If your 2 Step PPD was completed May 1, your annual 1 Step PPD MUST be completed no later than May 1 the following year.
- **If your PPD is positive**, you must have a chest x-ray immediately following the result. A chest x-ray is then required every 2 years.
- **If your PPD is positive**, a PPD symptom assessment form must be completed yearly.
- **The Seasonal Flu vaccine** is not required for the Summer Semester. It is required for Fall and Spring semesters.
- **The COVID vaccine** is not mandatory to attend HGTC. If you received ANY COVID vaccinations, please upload your card or proof. If you have not received any doses, please answer No in your Castle Branch tracker.
- **Hepatitis B** - There are 4 options to choose from.
  Option 1 – Proof of Hepatitis B Immunizations: Provide a copy of your immunization record showing you received the Hepatitis B series. This can be from a childhood, school or military immunization record.
  Option 2 – Reactive Hepatitis B Surface Antibody Titer: Provide a copy of the Hepatitis B surface antibody titer lab results showing you are immune to Hepatitis B. If your titer is NON-REACTIVE, you must receive a booster with proof of a prior immunization record OR go to Option 4 and complete the declination. If an immunization record is not available, you must receive the series OR go to Option 4 and complete the Declination.
  Option 3 – Series in Progress - Start the 3-dose series, with the 1st dose now, 2nd dose in one month, 3rd dose should be five months after the 2nd dose. There is also a 2-dose series available which is 4 weeks apart (Dynavax /Heplisav-B).
  Option 4 – Declination Waiver - You may opt out. Please see the Hepatitis Declination Waiver on page 16. Check the second box, sign & date.
- **MMR and Varicella** - There are 2 options to choose from.
  Option 1 – Proof of MMR and Varicella Immunizations: Provide a copy of your immunization or medical record showing you received 2 MMR and 2 varicella doses. This can be from childhood, school or military records.
  Option 2 – MMR and/or Varicella IgG Titer: Measles, mumps, rubella and varicella titers are only recommended if there is no proof of the vaccination history, but the student is certain they received the vaccines in the past. Positive results mean you are immune, and no additional vaccines or testing are required. Negative titer results (non-immune) may require re-vaccination, with no repeated titers required.
- **Liability Insurance** – The Certificate of Liability must be submitted. A copy of the application or proof of payment will be rejected. If you change programs, your specialty must be changed on your policy. Example, if you are a Phlebotomy student in the spring and then go into the Radiology program for summer, the specialty on your policy must be changed from Phlebotomist to Radiology Technologist.

careLearning

Completing the below Care Learning modules expedites the orientation process and facilitates the completion of basic regulatory training requirements prior to entering a healthcare facility. To get started, create a new account or re-use your existing account at: **http://passport.carelearning.com.**

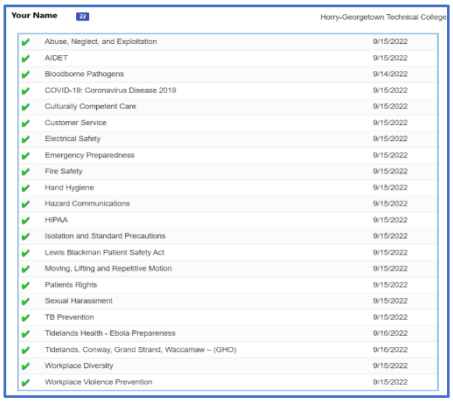
- Use **your school issued HGTC email account** when creating your Care Learning account. The program will require you to verify your account during the process.
- You will purchase courses and have access to them for 365 days. The total cost is $15.00. **The modules must be completed yearly** unless they expire during the semester. If so, you will click on **Repurchase** to complete the updated modules again prior to the start of the semester.

- Below are the **28 modules** that must be completed for Horry-Georgetown Technical College.
- When you Enter the Classroom, you MUST **manually ADD these 3 modules** by clicking Add Courses:

- **MUSC Health Florence, Marion, Black River Orientation**
- **Tidelands, Conway, Grand Strand, Waccamaw (GHO)**
- **Tidelands – Ebola Prepareness**

✔ Abuse, Neglect, and Exploitation	✔ Lewis Blackman Patient Safety Act
✔ AIDET	✔ Moving, Lifting and Repetitive Motion
✔ Bloodborne Pathogens	✔ MUSC-Florence, Marion, Black River Orientation
✔ COVID-19: Coronavirus Disease 2019	✔ Pain Management
✔ Culturally Competent Care	✔ Patients Rights
✔ Customer Service	✔ Population Specific Care: Pediatric
✔ Electrical Safety	✔ Population Specific Care: The Adult Patient
✔ Emergency Preparedness	✔ Sexual Harassment
✔ Fire Safety	✔ Slips, Trips, and Falls
✔ Hand Hygiene	✔ TB Prevention
✔ Hazard Communications	✔ Tidelands Health - Ebola Prepareness
✔ HIPAA	✔ Tidelands, Conway, Grand Strand, Waccamaw – (GHO)
✔ Infection Prevention and Control for Non-Clinical Employees	✔ Workplace Diversity
✔ Isolation and Standard Precautions	✔ Workplace Violence Prevention

- When all modules are complete, please upload a copy of your transcript to your Castle Branch tracker.



- If you need technical support, call 866-617-3904 or email support@carelearning.com Monday-Friday 8am-6pm.

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____

CPR: BASIC LIFE SUPPORT FOR HEALTHCARE PROVIDERS FORM

CPR REQUIREMENT:

- Basic Life Support Certification for the Healthcare Provider by American Heart Association (AHA) or American Red Cross (ARC) only
- Must renew CPR certification every 2 years

CPR Completion Date:	Certifying Agency:	Instructor's Initials:	
	☐ AHA ☐ ARC		

Certification:

☐ Yes, this student completed the **BLS CPR Certification for Healthcare Providers** through AHA or ARC.

_____

Instructor Printed Name Instructor Signature Date

CPR Instructor Affiliation _____

NOTE: If you are not receiving your CPR card/certificate the day of your class, please take this HGTC CPR BLS form with you so your instructor can complete it on your behalf. This form is valid for 30 days. You will need to remit a copy of your BLS CPR card/certificate within 30 days after your class.

To retrieve your card online from the American Heart Association, go here - https://ecards.heart.org/student/myecards

To retrieve your card online from the American Red Cross, go here - https://www.redcross.org/take-a-class/digital-certificate

Some area CPR/BLS Vendors – Others are also available

Prices and Information Subject to Change

Class Must Be:
BLS (Basic Life Support) Certification for Healthcare Provide
from the American Heart Association or the American Red Cross ONLY

Horry-Georgetown Technical College – Workforce Development – Courtney Sterbenz, Program Manager Cost: $165.00 (Scholarships are available) 950 Crabtree Lane, Building 600, Rm 631 Myrtle Beach, SC 29577 | courtney.sterbenz@hgtc.edu 843-477-2020 OR 843-477-2079 Dates of CPR classes can be found at www.hgtc.edu/jobtraining under Allied Health.	**Horry County Fire & Rescue** 2560 Main St Suite 1 Conway, SC 29526 | 843-915-5190 Melissa Rabonbrownm@horrycountysc.gov Cost: Online Portion - $32.50 - **www.onlineaha.org** In Person Skills - $15 www.horrycountyfirerescue.com/training
Bless Your Heart - CPR Cost: $45.00 (Materials Included) 843-457-3305 holly.wittschen@yahoo.com Holly Wittschen	**Andy Brown** Cost: $65 Myrtle Beach Area 843-957-0124 ambrownl2345@gmail.com
Midway Fire Department Battalion 82 Training Solutions, LLC Pawleys Island / Litchfield Area 843-545-3627 OR 843-267-2300 cgilmore@gtcounty.org OR mfdbc82@gmail.com http://www.midwayfirerescue.org	**Shannon & Greg Raxter** **Carolina Hartsavers** Cost: $85 (Materials Included) 843-333-8705 snraxter@gmail.com
Pee Dee Regional CTC Training Center ID: SC05608 1209 W Evans St Florence, SC 29501-3406 8436654671 carolinacenter@bellsouth.net http://PDCTC.COM	**Robeson Community College** 5160 Fayetteville Road Lumberton, NC 28360 Kenny Locklear rccems@robeson.edu 910-272-3407
Pee Dee Regional EMS 1314 W Darlington St Florence, SC 29501-2122 | 8436625771 Kim Dorsett – kim@pdrems.com www.pdrems.com http://www.pdrems.com	**Grand Strand Regional Medical Center** Class conducted at Coastal Grand Mall 2000 Coastal Grand Cir Suite 520 Myrtle Beach, SC 29577 843-839-9933 Dalena.nguyen2@hcahealthcare.com

All students must be Basic Life Support (BLS) CPR Certified through the American Heart Association (AHA) or American Red Cross (ARC). Certification is offered in two (2) formats, **Blended Learning** and an all **In Person Classroom Training**. For the blending learning, the first portion is completed online. Then the second portion, the hands-on skills assessment, MUST be completed in person. If you select one of the vendors above, their class may be the all **In Person Classroom Training**. Therefore, check with the instructor FIRST before purchasing the online portion.

NOTE: If you are not receiving your CPR card/certificate the day of your class, please take the HGTC CPR/BLS Form with you so your instructor can complete it on your behalf. The form is valid for 30 days. You will need to remit a copy of your BLS CPR card/certificate within 30 days after your class.

HORRY GEORGETOWN TECHNICAL COLLEGE

Health Science Division – Student Health Record

Student Name: _____

Student H#_____

Please print in ink or type Section I before going to your physician for examination. Be sure to answer all questions fully and include your name at the top of each page. Health information, including immunization records will be released to authorized clinical agencies with your consent (as designated by your signature on page 2). Students will not receive clearance for clinical without a complete record. Students must submit the completed "Student Health Record" prior to program matriculation. If you have questions concerning a disability, or if requesting reasonable accommodations contact Student Counseling Services at 349-5302. If requesting accommodations, you must provide appropriate medical, psychological and/or psychiatric documentation to support this request.

SECTION I (to be completed by student)

Name: _____
(Last) (First) (Middle)

Other Name(s) Student Known As: _____ Birthdate: _____

Home Address: _____
(Street) (City) (State) (Zip)

Telephone: _____
(Home) (Cell) (Work)

Medical History: ALLERGIES: _____

Have you had or do you have? CHECK Yes or NO	Yes	No	**Have you had or do you have? CHECK Yes or NO**	Yes	No
Rubeola			Stomach/Intestinal Abnormality		
Rubella			Arthritis		
Mumps			Asthma		
Chicken pox (MD documented)			Hay fever		
Infectious Mono			Color blindness		
Positive TB Skin Test			Recurrent headaches		
Recurrent Herpes Viruses			Back problems		
Sexually Transmitted Disease			Organ transplant		
Heart disease			Insomnia		
Heart murmurs			Frequent Anxiety		
Mitral Valve Prolapsed			Frequent Depression		
High Blood Pressure			Worry or Nervousness		
Rheumatic fever			Hepatitis (specify: A,B,C,D,E)		
Diabetes			Epilepsy/Convulsions		
Kidney/Bladder Abnormality			Other (explain below):		

If you check any of these conditions, more information is required in the next section.

HORRY GEORGETOWN TECHNICAL COLLEGE

Health Science Division – Student Health Record

Student Name: _____

Student H#_____

PHYSICAL PAGE 2 of 4

If you checked "Yes" to any medical history on the previous physical page, please give dates and treatments:

_____

_____

Please list any other medical conditions not addressed above:

_____

Please list all medications that you are currently taking:

_____

Student Signature _____ **Date** _____

SECTION II: Physical Examination (To be completed by the physician, physician assistant, or nurse practitioner)

Directions: Please review Section I completed by the student and then complete all of the following items in Section II.

Height: _____ Weight:_____ Blood pressure: _____ Pulse:_____ Respirations: _____ Temp:_____

Corrected Vision: RIGHT: 20/_____ Hearing: (Please circle)
LEFT: 20/_____ RIGHT: Normal Impaired LEFT: Normal Impaired

A. Does the student have any changes and/or concerns in the following systems? (Give dates, description of change, and treatment of ALL findings below)

System	**Yes**	**No**	System	**Yes**	**No**
Eyes			Musculoskeletal		
Ears			Metabolic/Endocrine		
Nose, throat			Genitourinary		
Neurological			Skin		
Respiratory			Immunological		
Cardiovascular (including murmurs)			Psychiatric		
Gastrointestinal			Other (please explain)		

B. If you have answered "yes" to any item in **A** above, please complete the following: (Additional information may be provided on a separate page identified with student's name).

Date	Diagnosis	Treatment	Restrictions/Limitations (Bending, lifting, pulling, etc.)

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ **PHYSICAL PAGE 3 of 4**

ESSENTIAL FUNCTIONS REQUIRED OF STUDENTS FOR ADMISSION AND PROGRESSION IN THE NURSING AND HEALTH CARE SCIENCE PROGRAMS

The following standards are considered essential criteria for participation in the Nursing and Health Science Programs. Students selected for Nursing or one of the Health Science programs must be able to independently engage in educational activities and clinical training activities in a manner that will not endanger clients/patients, other students, staff members, themselves, or the public. These criteria are necessary for the successful implementation of the clinical objectives of the Nursing and Health Science Programs. In order to be admitted, or to be retained in the Nursing or one of the Health Science Programs after admission, all applicants with or without accommodations must:

- **Possess sufficient visual acuity to independently read and interpret the writing of all size**.
- **Independently be able to provide verbal communication to and receive communication from clients/patients, members of the health care team, and be able to assess care needs through the use of monitoring devices, stethoscopes, infusion pumps, fire alarms, and audible exposure indicators, etc**.
- **Possess sufficient gross and fine motor skills to independently position and assist in lifting client/patients, manipulate equipment, and perform other skills required in meeting the needs of nursing care.**
- **The student (Observer) is free of communicable illnesses.**

Does the student have any restrictions/limitations?	**Yes**	_____	**No**	_____
If yes, how many weeks are restrictions/limitations in effect:				
If yes, what date will the restrictions/limitations be lifted:				
If yes, will the student be required to follow-up with your office:	Yes	_____	No	_____
If yes, date of scheduled appointment for follow-up:				

I hereby certify to the best of my knowledge that the preceding information is complete and accurate.

_____ _____

Print Name of Physician, Physician Assistant, or Nurse Practitioner Office if Applicable

_____ _____

Signature of Physician, Physician Assistant, or Nurse Practitioner Date

NOTE: Some NURSING AND HEALTH SCIENCE programs may have additional requirements. Individual students assume responsibility for ensuring all requirements have been met according to the designated curriculum for the program of which he/she is seeking entry.

WAIVER OF REPEAT PHYSICAL EXAMINATION / NOTIFICATION OF CHANGE IN HEALTH STATUS

Your initial Health Science Division – Student Health Physical Record is valid for one year. If you have had no changes in your medical history, you are eligible to complete this Waiver/Notification Form. If you have had any changes in your medical status, you are required to complete a new Health Science Division – Student Health Physical Record.

I, _____, as a student enrolled in a Nursing or Health Science Program at Horry-Georgetown Technical College, do hereby declare that I have sustained no changes in my physical health condition from my most recent student health examination required for the program.

- It is my understanding that in the event a physical health change occurs, it is my responsibility to immediately notify the following individuals of such change(s):
    1. Primary Course instructor and Clinical Instructor
    2. Clinical Admissions Office
- Following notification of health physical change(s), it is my responsibility to:
    1. Make an appointment with a healthcare provider for physical examination and completion of a new Health Science Division – Student Health Physical Record.
    2. Provide the completed Student Health Physical Record to the Clinical Admissions Office for verification of current eligibility for clinical without restrictions (specifically page 3 of health physical).
    3. Contact Student Affairs at (843) 349-5249 if you would like to request accommodations.
- If restrictions are indicated on the Student Health Physical Record, the Clinical Admissions Office will notify the student's designated Program Department Chair and/or Dean for guidance regarding further clinical continuation.
- In the event I fail to notify the appropriate individuals of such health changes, Horry-Georgetown Technical College is released from all liability relevant to my physical health status, and such failed actions on my behalf may result in dismissal from the program of study and/or constitute legal action thereof.

Student Printed Name	Student Signature	Date

HORRY GEORGETOWN TECHNICAL COLLEGE

Health Science Division – Student Health Record

Student Name: _____

Student H#_____

Tuberculosis Screening

HGTC students are initially required to complete a 2-Step PPD, which consists of two tuberculin skin tests (4 office visits) **OR** a QuantiFERON (QFT) Gold Blood Assay, which is a blood draw to test for Tuberculosis. A 1-Step PPD or QFT Gold Blood Assay is required yearly after the initial process if completed within the same one year.

If you elect to have the QuantiFERON (QFT) Gold Blood Assay, submit a copy of the lab results.

If you elect to have the tuberculin skin test(s), the below section is **TO BE FULLY COMPLETED BY A HEALTHCARE PROVIDER:**

1st Step – Visit 1:

Date Administered: _____ Time: _____

Site: (please circle) Left FA Right FA Lot#:_____ Expiration Date:_____

Healthcare Provider Signature test was administered: _____

Your PPD must be read within 48-72 hours.

1st Step – Visit 2: ***Results:*** (please circle) Negative Positive

Date Read:_____ Time Read:_____ Induration:_____mm

Healthcare Provider Signature test was read: _____

Step 2 should be administered 7-21 days after Step 1 was administered.

There is a max time frame of 21 days between Step 1 and Step 2

2nd Step - Visit 3:

Date Administered: _____ Time: _____

Site: (please circle) Left FA Right FA Lot#:_____ Expiration Date:_____

Healthcare Provider Signature test was administered: _____

Your PPD must be read within 48-72 hours.

2nd Step – Visit 4: ***Results:*** (please circle) Negative Positive

Date Read:_____ Time Read:_____ Induration:_____mm

Healthcare Provider Signature test was read: _____

- If the QFT or PPD result is **POSITIVE** (>10 mm induration), a student must have a medical assessment, provide TB results, proof of negative CXR and complete the symptom assessment form.
- Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____

INFLUENZA FORM

The seasonal flu vaccine is required for the Fall and Spring semesters. It is not required for the Summer semester. It typically is available every August and will be due in September.

Lot #	Manufacturer:	Expiration:	Injection Site:	Date	Initials

Certification:

Signature below indicates verification of above initials in administration of, or reporting of, documented result for Influenza Immunization(s).

_____

Healthcare Provider Signature Title Date

Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#: _____

Tetanus, Diphtheria, Pertussis (TDAP) Form

This form must be complete or an immunization record is needed.

Lot #	Manufacturer:	Expiration:	Injection Site:	Date	Initials

Certification:

Signature below indicates verification of above initials in administration of TDAP immunization.

Healthcare Provider Signature Title Date

Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.

HORRY GEORGETOWN TECHNICAL COLLEGE

Health Science Division – Student Health Record

Student Name: _____

Student H#: _____

HEPATITIS B FORM

Option 1 – Proof of prior Hepatitis B Immunization: Provide a copy of your immunization record showing you received the Hepatitis B series. This can be from a childhood, high school or military immunization record.

Option 2 – Reactive Hepatitis B Surface Antibody Titer: Provide a copy of the Hepatitis B surface antibody titer lab results showing you are immune to Hepatitis B. If your titer is NON-REACTIVE, you must receive a booster with proof of a prior immunization record. If an immunization record is not available, you must receive the series OR go to Option 4 and complete the Declination.

Option 3 – Series in Progress: If you elect to receive the series, please circle which series:
3-dose series or **2-dose series** or **1 booster** (will include prior immunization record with this form)
You MUST also check the Series in Progress box below and sign with your signature and date.
This form must be complete or an immunization record is required. "Historical" with the dates will not be accepted.

Injection	Lot #	Manufacturer:	Expiration:	Injection Site:	Date	Healthcare Provider Signature
1.						
2.						
3.						

☐ I am in the process of receiving the Hepatitis B Vaccine and will provide documentation of all vaccinations as they are completed. Until I am fully vaccinated, 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.

_____

Student Signature **H#** **Date**

Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.

Option 4 – Declination Waiver:

☐ 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. I have been informed of the opportunity to be vaccinated with Hepatitis B Vaccine. 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. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I will decide at that time.

_____

Student Signature **H#** **Date**

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#: _____

MEASLES, MUMPS, RUBELLA (MMR) and VARICELLA (CHICKENPOX) FORM

Option 1 – Proof of MMR and Varicella Immunizations: Provide a copy of your immunization or medical record showing you received 2 MMR and 2 varicella doses. This can be from childhood, school or military records.

Option 2 – MMR and/or Varicella IgG Titer: Measles, mumps, rubella and varicella titers are only recommended if there is no proof of the vaccination history, but the student is certain they received the vaccines in the past.

- Positive results mean you are immune, and no additional vaccines or testing are required.
- Negative titer results may require re-vaccination, with no repeated titers required.

To be completed by a healthcare provider ONLY if your titer lab results show non-immunity or if you are receiving the series. Please do NOT record historical vaccinations here.

Injection	Lot #	Manufacturer:	Exp Date:	Injection Site:	Date	Healthcare Provider Signature
MMR #1						
MMR #2 (without prior immunization record						

Injection	Lot #	Manufacturer:	Exp Date:	Injection Site:	Date	Healthcare Provider Signature
Varicella #1						
Varicella #2 (without prior immunization record						

Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.

An additional titer is not required.

PROFESSIONAL LIABILITY INSURANCE

Required for the following Nursing and Health Science Programs

Computerized Axial Tomography	Phlebotomy (AHS 167)
Dental Assistant (DAT)	Physical Therapy Assistant (PTH)
Dental Hygienist (DHG)	Practical Nursing (LPN/PNR)
Diagnostic Medical Sonography	Radiology Technology
Medical Lab Technology	Registered Nurse (NUR/ADN)
Occupational Therapy Assistant	Respiratory Care
Paramedic	Surgical Technology
Patient Care Medical Technician (AHS 163)	Vascular Sonography

If you change programs, your specialty must be changed on your policy.

Example, if you are a Phlebotomy student during the spring semester and then go into the Radiology program for the summer semester, your policy must be changed from Phlebotomist to Radiology Technologist.

Students may choose a vendor of their choice; however, coverage amounts must be as stated as below.

One 3rd party vendor is Healthcare Providers Service Organization (HPSO)
www.hpso.com – 1-800-982-9491

On the HPSO website, click "Get a Quote" > Select "Students" and "Get Started" > Follow the prompts as a "Student"

Minimum Coverage: $1,000,000 each claim and $3,000,000 aggregate

You will receive an email confirming your application was submitted.

Within 24-48 hours, you will receive an email containing your actual Policy.
We will need the **Certificate of Liability** for proof, not a copy of the application or proof of payment.

Clinical Forms & Disclosures

Click on your program below to access the required clinical forms and disclosures.
Be sure to enter your full name and use your @hgtc.edu email account only.

The system will automatically send us a copy of your completed forms.
You do not need to email us stating they are complete.
You will have the option to download or print the completed forms for your records.

****When entering your birthdate on the forms, you may manually enter your DOB by entering MM/DD/YEAR or you may click on the year to select your birth year, then the month and day.**

Diagnostic Medical Sonography / Vascular Sonography

Health Care Certificate / Patient Care Medical Assistant

Medical Laboratory Technology

Nursing ADN & PN

Occupational Therapy Assistant

Paramedic

Phlebotomy

Physical Therapist Assistant

Radiologic Technology / Computerized Axial Tomography

Respiratory Care

Surgical Technology

If you experience any issues while completing the forms,
please contact us at hgtc-clinical@hgtc.edu.

Immunization Cost Estimates for Students
WITHOUT Health Insurance Coverage
Some of these ARE covered under most health insurance plans

DISCLAIMER: This information is to be used as a guide only, as it is subject to change. HGTC cannot be held responsible for the prices listed below. It is the student's responsibility to call and confirm availability, pricing, and insurance requirements. HGTC is not affiliated with any of these providers regarding provision of healthcare services and is unable to recommend any specific provider.

You do not have to use these providers. YOU MAY USE YOUR OWN PROVIDER.

The prices below are from September 2023. They are subject to change. Call ahead for pricing.

Immunization	Care Now 843-626-2273 (7 Locations)	CVS Minute Clinic 866-389-2727	Doctor's Care 843-238-1461	South Strand Internist & Urgent Care 843-945-3030	**McLeod Health Carolina Forest 843-646-8400	BraVa Health 843-750-0324	Southern Urgent Care 843-357-4357
Office Visit Fee	$180.00	NA	$150.00	$95 - $171	NA	$80.00	$130.00
Physical – Included in Office Fee	180.00	$75.00 - $100.00	$100.00	$80.00	$50.00	$80.00	$45.00
Tuberculin Skin Testing (PPD) x 1 OR *QFT Gold Blood Assay	$75.00 (PPD) $100.00 (QFT)	$74.00 - $139.00 (PPD)	$34.00 $60.00 (QFT)	$19.00 $112.00 (QFT)	$10.00 (1 PPD) $52.00 (QFT)	$25.00 (PPD) $100 (QFT)	$35.00 (PPD) $110.00 (QFT)
Chest X-Ray with Positive PPD	$235.00	NA	$75.00 - $90.00	$31.20 - $98.80		NA	$100.00
MMR IgG Titer	$110.00	$99 - $139	$100.00	NA	$14.75 for MMRV	$60.00	$50.00
Varicella IgG Titer	$17.00	$99 - $139	$100.00	NA		$30.00	$50.00
Hep B Surface Titer	$41.00	$99 - $139	$100.00	NA	$6.50	$30.00	$30.00
MMR Vaccine x 1	$110.00	$143.00	NA	$100.00	$105.00	NA	NA
Hep B Vaccine 2 Dose / 3 Dose	2 Dose -$165.00 ea 3 Dose - $95.00 ea Admin Fee - $52.00	$153.00 ea	2 Dose $175 w admin fee	$150 ea w admin fee	2 Dose - $122.50 ea 3 Dose - $60.00 ea	NA	NA
Varicella Vaccine x1	NA	$229.00 ea	NA	$172.00	$200.00	NA	NA
TDAP (Adacel) Vaccine	$75.00	$103.00	$71.00	$45.00	$58.00	NA	$75.00
Flu	$20.00	$75.00 - $100.00	$40.00	$37.00	$25.00	NA	NA

****If visiting Mcleod Health (listed above), you must make an appointment & inform them you are an HGTC student to receive these prices. Be sure to show them your student ID at your appt.****

These offices offer pricing on a sliding scale:

- Little River Medical Center, Little River, SC 843-663-8000
- Careteam +, Conway, SC, www.careteamplus.org, 843-234-0005

For students who meet certain income guidelines, some services are provided at low or no cost through **the SC Health Departments**. Call (855) 472-3432 to make an appointment at any of these locations.

- Myrtle Beach Health Dept, 21st Ave, Myrtle Beach (843) 448-8407
- Conway Health Dept., Industrial Park Road, Conway (843) 915-8800
- Stephen's Crossroad Health Dept., Hwy 57 North, Little River (843) 915-5654
- Georgetown County Public Health Department, Lafayette Cir, Georgetown (843) 546-5593

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#: _____

SYMPTOM ASSESSMENT FORM – Required ONLY with Positive TB Test
(Required Yearly)

Instructions:
*Complete this form **ONLY** if you had a Positive (+) Tuberculosis Test with a Negative (-) CXR.*

Date: _____ Date of Positive PPD: _____ Date of Negative CXR: _____

Have you been treated with tuberculosis medication? ❑ Yes ❑ No

Have you ever received a BCG (tuberculosis vaccine)? ❑ Yes ❑ No

Have you been exposed to an isolated case of TB this year? ❑ Yes ❑ No

Do you have any of the following?

- Productive cough (≥ 3 weeks) ❑ Yes ❑ No
- Persistent weight loss without dieting ❑ Yes ❑ No
- Persistent low-grade fever ❑ Yes ❑ No
- Night sweats ❑ Yes ❑ No
- Loss of appetite ❑ Yes ❑ No
- Swollen glands in the neck ❑ Yes ❑ No
- Recurrent kidney or bladder infections ❑ Yes ❑ No
- Coughing up blood ❑ Yes ❑ No
- Shortness of breath ❑ Yes ❑ No
- Chest pain ❑ Yes ❑ No

If you answered "YES" to any of the above questions, please explain:

_____

_____

_____

(Note: Clearance from a primary care provider, which may include repeat CXR, is required prior to clinical attendance if you answered "YES" to any of the above questions).

Student's Signature: _____ Date: _____

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#: _____

VACCINE MEDICAL WAIVER FORM

Vaccine	Contraindication to student receiving vaccine:	Initials
❑ TST/PPD ❑ Influenza ❑ TDAP ❑ Hepatitis B ❑ MMR ❑ Varicella	❑ Documented Allergy to Vaccine or Component of Vaccine *Additional information required below.* ❑ **Pregnancy** EDC: _____ • Must be for live virus vaccine. • Date Vaccine can safely be administered _____ ❑ Currently Immunosuppressed/Immunocompromised • Disease/Condition: _____ • Date Vaccine can be safely administered _____	

If requesting a Medical Exemption, please have your physician complete and sign below.

[ ] Anaphylaxis [ ] Guillain-Barré Syndrome [ ] Other Severe Reaction or medical condition:
Please specify reaction/condition:

_____

_____

_____

_____

Certification:
Signature below indicates **verification of above initials** in reporting of valid contraindication for student not receiving designated vaccine.

_____

Provider Name Provider Address Provider Phone Number

_____

Signature Must be signed by a MD or DO Date

_____