Health Tracker Clinical Requirements

for

Massage Therapy

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Massage Therapy
Clinical Requirements Checklist

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IMPORTANT NOTES

- Any item that will expire mid semester must be completed before the semester begins. Example, your TB test / QFT expires in March, you must renew your certificate before classes start in January.

- **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.

- **Hepatitis B** - There are 4 options to choose from.
  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 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** - There are 2 options to choose from.
  Option 1 – Proof of MMR Immunizations: Provide a copy of your immunization or medical record showing you received 2 MMR doses. This can be from childhood, school or military records.
  Option 2 – MMR IgG Titer: Measles, mumps, and rubella 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.

Clinical Requirements Health Tracker Guide

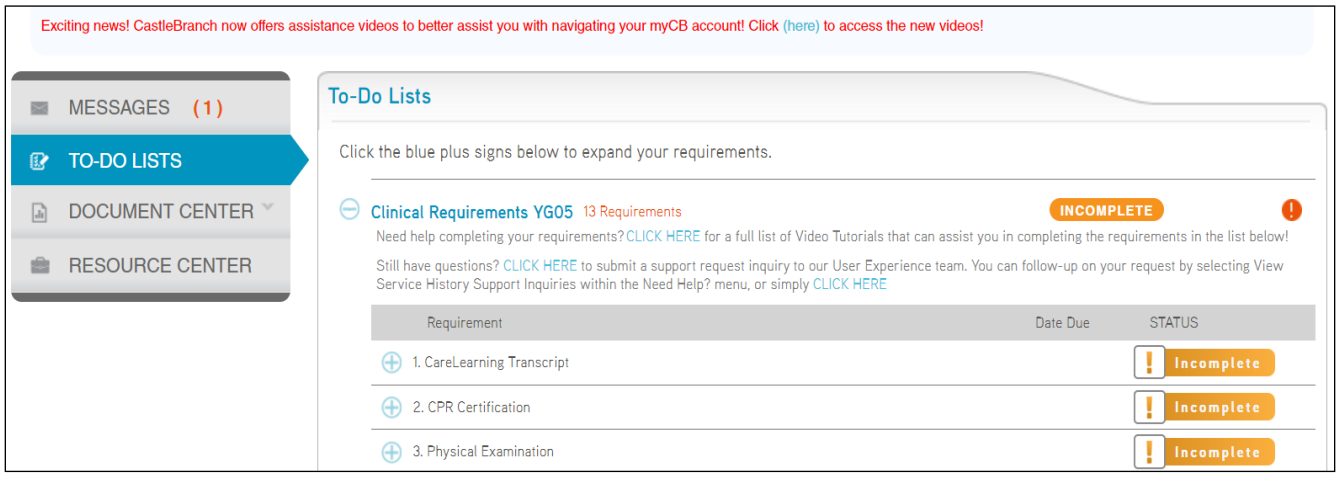
To be completed by ALL Nursing, Dental Sciences, EMT, Imaging Sciences, HealthCare Science, Physical and Occupational Therapy and Massage Therapy Students

How will the Clinical Admissions Office receive my clinical requirements documents?

- All clinical requirements documentation MUST be uploaded into the student's Castle Branch compliance tracker account.
- The fee for the Castle Branch Compliance Tracker is a one-time fee.
- If you already have a Castle Branch Compliance Tracker, you do not need to purchase another one if you return to your program or change programs.
- If you have an existing Castle Branch account, but have NOT purchased the compliance tracker AKA Medical Document Manager CRR, you must purchase it. We are unable to view documents that are uploaded to your Document Center.

- Click here to purchase and create your Castle Branch Tracker account - **https://portal.castlebranch.com/HB36/spif/HG89/HG89im**

- After creating your account, you will access your account by logging into **https://login.castlebranch.com**. Documents should be uploaded under TO-DO LISTS.



- If you experience any technical difficulties, please contact Castle Branch @ 888-666-7788. Their hours of operation are 8 AM – 8 PM, Monday – Thursday and 8 AM – 6:30 PM on Fridays.

Questions or concerns? Email us @ HGTC-Clinical@hgtc.edu

HORRY GEORGETOWN TECHNICAL COLLEGE

Health Science Division – Student Health Record

Student Name: _____

Student H#_____

Health Physical PAGE 1 of 4

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.

If you checked "Yes" to any past 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 - see 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.)

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 Allied Health Programs. Students selected for Allied Health 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 Allied Health Programs. In order to be admitted, or to be retained in the Allied Health Programs after admission, all applicants with or without accommodations must (by initialing the items you agree the student will be able to perform the function):

- **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 Name if Applicable

_____ _____

Signature of Physician, Physician Assistant, or Nurse Practitioner Date

NOTE: Some allied health 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 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#**_____

Tetanus, Diphtheria, Pertussis (TDAP) Form

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

Injection	Lot #	Manufacturer:	Expiration:	Injection Site:	Date	Healthcare Provider Signature
TDAP						

- 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) FORM

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

Option 2 – MMR IgG Titer: Measles, mumps, and rubella IgG 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						

An additional titer is not required.

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

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

_____