Health Registration

Complete and return 2 pages to Continuing Education.

Iowa Western Community College, Continuing Education, Looft Hall, 2700 College Road, Council Bluffs, IA 51503

FAX: 712-325-3721 Email: ce@iwcc.edu

Circle program for registration.

Phlebotomy	Sterile Processing	Mental Health	Pharmacy Technician

Course:	**Course #:**	**Course date:**

PERSONAL INFORMATION

NAME (*Lastname, First name Middle Initial*)	**DATE OF BIRTH** (*mm/dd/yyyy*)	**SSN:**

ADDRESS (*Number, Street, City, State Zip Code*)

TELEPHONE (*Home*)	**TELEPHONE** (*Mobile*)	**EMAIL ADDRESS**	**GENDER** ___Male ___ Female ___ Nonbinary
			CITIZENSHIP ____US _____ Other (Specify)

CRIMINAL BACKGROUND CHECK (Fill out one line for each name you have had (Married, Maiden, etc)

1. Current Last Name	**Current First Name**	**Current Middle Name**
2. Previous Last Name	**Previous First Name**	**Previous Middle Name**
2. Previous Last Name	**Previous First Name**	**Previous Middle Name**

Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime other than a simple misdemeanor offense relating to motor vehicles and laws of the road under chapter 321 or equivalent provisions in this state or any other state? No _____ Yes _____

I give Iowa Western Community College permission to complete an IOWA CRIMINAL HISTORY check. The information I have furnished is accurate and complete.

Signature _____ Date _____

PAYMENT METHOD:

☐ E2E	☐ Money Order	☐ Cashier's check	☐ Cash	☐ Credit Card

Credit/Debit Card #: **Exp. Date:** **3 Digit Code:**

Name on Card:

Billing Address:

Payee Email:

Required Immunizations

Must be completed and signed by your healthcare provider OR the provider may attach their own documentation to this application.

MMR (Measles, Mumps Rubella) **Two doses required for students born in 1957 or later.**

☐ a. Dose 1 given at age 12-15 months or later #1 ___/___/___ M D Y

Dose 2 given at age 4-6 or later, and at least one month after first dose. #2 ___/___/___ M D Y

OR

☐ b. Laboratory/serologic evidence of immunity (attach copy of lab report) ___/___/___ M D Y

Tuberculosis Screening

☐ a. Tuberculin Skin Test:

Date #1 given ____/____/_____ Date #1 Read ____/____/_____ Results _____

Date #2 given ____/____/_____ Date #2 Read ____/____/_____ Results _____ **OR**

☐ Chest X-ray (required if tuberculin skin test is positive) result: Normal _____ Abnormal _____

Date of Chest Xray ____ /____/_____ Attach copy of chest x-ray report

Hepatitis B Required for all students (Three doses of vaccine or a positive Hepatitis B Surface Antibody)

☐ 3 dose Hepatitis B Series

Date #1 ____/____/_____ #2 ____/____/_____ #3 ____/____/_____ **OR**

☐ 3 dose Hepatitis A and Hepatitis B Series

Date #1 ____/____/_____ #2 ____/____/_____ #3 ____/____/_____ **OR**

☐ Laboratory/serologic evidence of immunity or prior infection (attach copy of lab report) **___/___/_____**

Varicella (either a history of chicken pox, a positive antibody, or 2 doses of vaccine given at least one month apart if immunized after age 13.)

☐ History of disease verified by undersigned clinician ____/____/_____ **OR**

☐ Laboratory/serologic evidence of immunity or prior infection (attach copy of lab report) ____/____/_____

☐ 1 dose given at 12 months of age or later but before student's 13th birthday Date of shot ____/____/_____ **OR**

☐ 2 doses. Dose 1 given after student's 13th birthday. 2nd Dose at least one month after 1st dose.

Date #1 ____/____/_____ #2 ____/____/_____

Tetanus-Diphtheria-Pertussis (Primary series DTaP, DTP, DT, or Td, and booster with Td or Tdap in the last ten years.)

If students have not had Tdap as an adult, they are required to get one dose.

☐ Primary Series of four doses with DTaP, DTP,DT or Td

Date #1 ____/____/_____ #2 ____/____/_____ #3 ____/____/_____ #4 ____/____/_____

☐ Booster: Tdap (preferred) Date: ____/____/_____

Covid Vaccine: Please provide a copy of your Vaccination Card-Mandated for clinicals

☐ Brand given _____ Date ____/____/_____ Booster ____/____/_____

Influenza Vaccination Date ____/____/_____

Healthcare Provider: (signature or stamp required)

Name (Print) _____ Signature _____

Address _____

City _____ State _____ Zip_____

Phone _____ Date _____