

Health Requirement Checklist available here: stcc.edu/healthservices

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Early Childhood Education Programs (ECTR, CDA)

Health records (e.g. forms, vaccination, lab/imaging reports, etc.) may be submitted as follows:

In Person	Health & Wellness Center, Building 19, Room 177
Online	STCCNet Dropbox Direct link: tinyurl.com/27ychwv2
Fax	(413) 755-6045
Release Request	tinyurl.com/y4y4ruuo

Due within 10 days of acceptance

- CORI Acknowledgement Form** – Bring valid identification to the health services office or have form notarized and submit online. Form and instructions: tinyurl.com/stcc-cori. Required annually in order to register for classes.

Due prior to July 1st for Fall enrollees and Dec. 1st for Spring enrollees:

- Student Health History Form** - Complete the form at tinyurl.com/b7fdjh7v
- Auth. to Release Info. to Fieldwork Sites Form** - Complete the form at tinyurl.com/y34eglyt
- Technical Standards Acknowledgement Form** - Complete the form at tinyurl.com/y5o67f7o

Immunization/Immunity Records:

- tetanus, diphtheria and pertussis (TDaP)** - vaccine must have been administered within the past 10 years
- measles, mumps, rubella (MMR)** - 2 dose vaccine series OR titer results showing immunity
- hepatitis B** – 3 dose hepatitis B vaccine series (or 2-dose if HEPLISAV-B™)
OR titer (surface antiBODY, anti-HBs) lab report result showing immunity
- varicella (chickenpox)** - 2 dose vaccine series OR titer results showing immunity
- meningitis** - For students age 21 and younger taking 12 credits or more, 1 dose MenACWY(formerly MCV4) vaccine administered on/after 16th birthday; OR complete a [Meningitis Waiver](#) at tinyurl.com/y6svra7b

Additional Requirements:

- CPR Certification:** Students are required to maintain a current CPR certification as a graduation requirement. Only the following are acceptable: American Heart Association (AHA) Heartsaver Pediatric First Aid/CPR/AED, AHA Heartsaver CPR/AED with pediatric and infant modules, AHA BLS, Military Training Network BLS, Military Training Network Heartsaver CPR AED with pediatric and infant modules, American Red Cross (ARC) Adult and Pediatric First Aid/CPR/AED, ARC Adult First Aid/CPR/AED, and ARC Basic Life Support for Healthcare Providers
- First Aid Certification:** Students are required to maintain a current First Aid certification as a graduation requirement. Only the following are acceptable: American Heart Association (AHA) Heartsaver Pediatric First Aid/CPR/AED, AHA Heartsaver First Aid, American Red Cross (ARC) Adult and Pediatric First Aid/CPR/AED, ARC Adult First Aid/CPR/AED, ARC Emergency Medical Responder, American Heart Association

STCC Workforce Development Center certification course listing: stcc.edu/wdc/descriptions/#healthcare

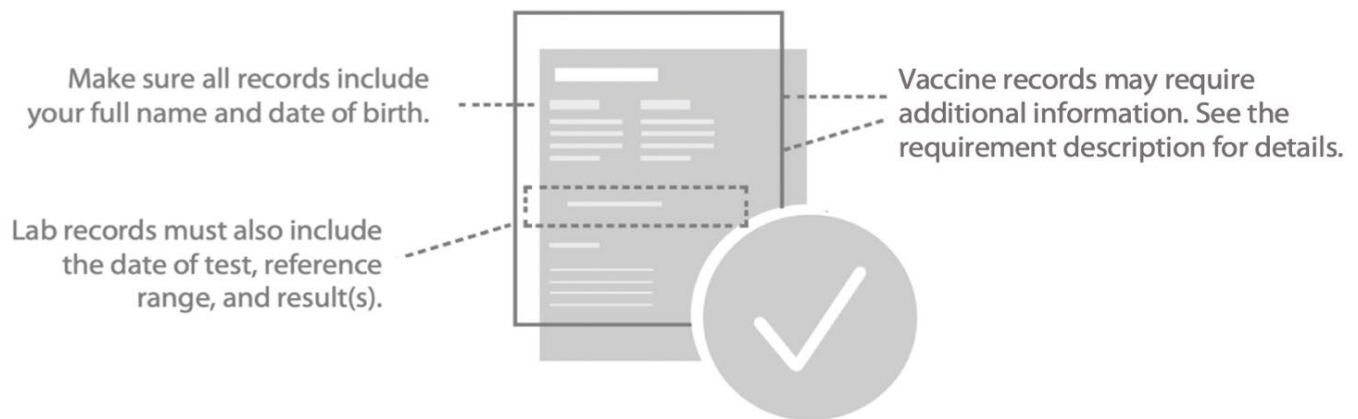
Health Requirement Checklist Early Childhood Education Programs (ECTR, CDA)

(continued from the previous page)

Additional Requirements:

- Health Insurance:** Fieldwork participants must have insurance. Students enrolled in 9+ credits self-certify through Student Financial Services.
- Fingerprinting:** If required by the fieldwork site, students will receive instructions from the program's practicum coordinator.

For more information, contact the Health & Wellness Center at stcc.edu/healthservices.



Understanding your titer (antibody serology) results

- Positive/Reactive means you have immunity.
- Negative/Non-Reactive/Indeterminate/Equivocal means you are not immune.
 1. Submit lab report and all immunization records to the Health and Wellness Center.
 2. Health and Wellness Center staff will advise you of next steps.

Students are encouraged to verify their immunity records when applying to the program. By doing so, upon acceptance, the student will be able to submit the required documentation. Record submission deadlines are set by the Early Childhood Education Program and must be submitted on time. Students may be excluded from fieldwork practicum until requirements are met.

Revised January 2022

Dear School of Health & Patient Simulation, Workforce Development, Early Childhood Education and Behavioral Science Students:

Background record checks are required for College programs involving potentially unsupervised contact with children, the disabled, or the elderly, including fieldwork (a clinical affiliation, internship, externship, or field placement) with a private or public healthcare provider or daycare provider. Such checks include data provided by the Massachusetts Department of Criminal Justice Information Services (DCJIS); the Office of Inspector General/General Services Administration (OIG/GSA); the Massachusetts Department of Children and Families (DCF); the Massachusetts Sex Offender Registry Board (SORB); the state and national fingerprint databases; as well as all relevant state and national criminal history, child welfare and sex offender registries, databases and repositories. The purpose of the background check is to ensure a safe and protective environment for all clients, particularly members of vulnerable populations.

Students choosing not to consent to the required background checks will be ineligible to participate in fieldwork involving vulnerable populations. Ineligibility to participate in fieldwork may affect a student's ability to successfully complete the program.

Based upon the results of the background checks, a student may be deemed ineligible to participate in academic or fieldwork activities, which may impact a student's ability to successfully complete program requirements. Background checks are reviewed by the College's CORI Board. The CORI Board determines eligibility to participate in academic and/or fieldwork activities. Students have the right to appeal the determination of the CORI Board by filing a written appeal with the Vice President of Student Affairs within 10 business days of receiving the CORI Board's determination. Furthermore, please be advised that eligibility to participate in College academic and/or fieldwork activities following a background check does not guarantee eligibility to sit for a professional credentialing examination(s) or for employment upon program completion. It is the student's responsibility to contact the certification or licensure board for a particular healthcare or other service profession to determine the standards that must be met for credentialing, licensing and/or employment in that field.

Instructions for Completing the CORI Acknowledgement Form

Due	WITHIN 10 DAYS OF ACCEPTANCE and annually thereafter
Why	Must be on record at the College before you are eligible to register/enroll
Valid Approved Identification (ID)	Form verification cannot occur without valid identification. <u>Examples:</u> state-issued driver's license, state-issued identification card with a photograph, passport, military identification card, or Native American Tribal documents. Temporary ID is not accepted.
Students Under 18 Years Old	Parent/guardian must also be present along with their valid approved ID.
Verification of Person(s)	The form signature(s) and person(s) may be verified/authenticated one of two ways: 1) Off campus by a Notary Public: The two page stamped/sealed form may be submitted to the Health and Wellness Center, B19/Room 177 electronically via STCCNet DropBox , or Fax: (413) 755-6045. <u>OR</u> 2) On campus: The two page form may be verified by the Health and Wellness Center staff, located in Building 19, Room 177. An original signature is required on the form along with a valid, approved ID for verification purposes.

For more information regarding the College's CORI/SORI check process, please feel free to contact me directly.

Sincerely,

Maryellen Baker, RN, CORI/SORI Review Officer

School of Health and Patient Simulation | Director of Health Compliance | mtbaker2001@stcc.edu



**Criminal Offender Record Information (CORI)
 Acknowledgement Form**

To be used by organizations conducting CORI checks for employment, volunteer, subcontractor, licensing, and housing purposes.

_____ STCC _____ is registered under the provisions of M.G.L. c.6, § 172 to receive CORI for the purpose of screening current and otherwise qualified prospective employees, subcontractors, volunteers, license applicants, current licensees, and applicants for the rental or lease of housing.

As a prospective or current employee, subcontractor, volunteer, license applicant, current licensee, or applicant for the rental or lease of housing, I understand that a CORI check will be submitted for my personal information to the DCJIS. I hereby acknowledge and provide permission to _____ STCC _____ to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing _____ STCC _____ with written notice of my intent to withdraw consent to a CORI check.

FOR EMPLOYMENT, VOLUNTEER, AND LICENSING PURPOSES ONLY:

STCC may conduct subsequent CORI checks within one year of the date this Form was signed by me, provided, however, that STCC, must first provide me with written notice of this check.

By signing below, I provide my consent to a CORI check and affirm that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

Signature of CORI Subject

Date

Signature of CORI Subject Guardian (if applicable)

Date



**THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF PUBLIC SAFETY AND SECURITY
Department of Criminal Justice Information Services**
200 Arlington Street, Suite 2200, Chelsea, MA 02150
TEL: 617-660-4640 | TTY: 617-660-4606 | FAX: 617-660-5973
MASS.GOV/CJIS



SUBJECT INFORMATION

Please complete this section using the information of the person whose CORI you are requesting.
The fields marked with an asterisk (*) are required fields.

* First Name: _____ Middle Initial: _____

* Last Name: _____ Suffix (Jr., Sr., etc.): _____

Former Last Name 1: _____

Former Last Name 2: _____

Former Last Name 3: _____

Former Last Name 4: _____

* Date of Birth (MM/DD/YYYY): _____ Place of Birth: _____

* Last **SIX** digits of Social Security Number: _____ -- _____ No Social Security Number

Sex: _____ Height: _____ ft. _____ in. Eye Color: _____ Race: _____

Driver's License or ID Number: _____ State of Issue: _____

*Program: _____

Father's Full Name: _____

Mother's Full Name: _____

Current Address

* Street Address: _____

Apt. # or Suite: _____ *City: _____ *State: _____ *Zip: _____

Authentication of Signature or Person: Two Options (Choose One)

1) OFF CAMPUS: Notary Public Authentication of Signature or Person

Please note that ALL fields in this section must be completed by the Notary Public.

On this ____ day of _____, 20 ____, before me, the undersigned Notary Public, personally appeared _____ (name of CORI requestor) and proved to me through satisfactory evidence of identification, which was _____ (Ex: Driver's license, passport, etc.), to be the person whose name is signed on the preceding or attached document, and acknowledged to me that (he)(she) signed it voluntarily for its stated purpose.

Signature of Notary Public
(Notary stamp or seal is also required)

Date my Commission expires

2) ON CAMPUS: IN PERSON VERIFICATION

OFFICIAL USE ONLY: To be completed by VERIFYING EMPLOYEE AT STCC

The above information was verified by reviewing the following form(s) of government-issued identification: _____

PRINTED, DATED AND SIGNED NAME OF VERIFYING EMPLOYEE

NOTARY STAMP HERE

Health and Wellness Center · Building 19, Room 177 · Phone (413) 755-4230 · Fax (413) 755-6045

Student Health History Form

This form is available online at: www.stcc.edu/healthservices

Please return form to the Health and Wellness Center (students may fill in information on this form)

MAJOR: _____	Student ID# _____		
NAME: _____			
(last)	(first)	(middle)	
ADDRESS: _____			
(street)	(city)	(state)	(zip code)
BIRTH DATE: _____	TELEPHONE NUMBER: _____		

IN CASE OF EMERGENCY PLEASE CONTACT: _____		
(name)	(phone)	(relation)

DO YOU HAVE ANY SPECIALIZED NEEDS IN THE EVENT OF AN EMERGENCY OR A BUILDING EVACUATION?

Check at left of each item. If “yes”, explain as appropriate

YES	NO	HEALTH HISTORY
<input type="checkbox"/>	<input type="checkbox"/>	1. Hospitalization (date, reason)
<input type="checkbox"/>	<input type="checkbox"/>	2. Operation (date, type)
<input type="checkbox"/>	<input type="checkbox"/>	3. Serious accidents or illnesses
<input type="checkbox"/>	<input type="checkbox"/>	4. Prescription medications? Please list with reason for taking here:
<input type="checkbox"/>	<input type="checkbox"/>	5. Are you currently taking any non-prescription medications, vitamins or diet supplements? If so, please list here:
YES	NO	ALLERGIES to MEDICATIONS and/or ENVIRONMENTAL FACTORS
<input type="checkbox"/>	<input type="checkbox"/>	6. Allergies to medications? If so, please list:
<input type="checkbox"/>	<input type="checkbox"/>	7. Life threatening reaction to insect bites, food, etc.? If so, please specify:
<input type="checkbox"/>	<input type="checkbox"/>	8. Do you carry an epinephrine injection kit?

YES	NO	HAVE YOU EVER HAD:
<input type="checkbox"/>	<input type="checkbox"/>	9. Chicken Pox
<input type="checkbox"/>	<input type="checkbox"/>	10. Epilepsy (convulsions)
<input type="checkbox"/>	<input type="checkbox"/>	11. Head injury or concussion
<input type="checkbox"/>	<input type="checkbox"/>	12. Fainting or dizziness
<input type="checkbox"/>	<input type="checkbox"/>	13. High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	14. Any heart problems
<input type="checkbox"/>	<input type="checkbox"/>	15. Chronic or persistent respiratory infection
<input type="checkbox"/>	<input type="checkbox"/>	16. Asthma
<input type="checkbox"/>	<input type="checkbox"/>	17. Gastrointestinal disease
<input type="checkbox"/>	<input type="checkbox"/>	18. Gallbladder disease
<input type="checkbox"/>	<input type="checkbox"/>	19. Thyroid problem
<input type="checkbox"/>	<input type="checkbox"/>	20. Mononucleosis (diagnosed by a clinician)
<input type="checkbox"/>	<input type="checkbox"/>	21. Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	22. Immune Deficiency Problems
<input type="checkbox"/>	<input type="checkbox"/>	23. Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	24. Cancer
<input type="checkbox"/>	<input type="checkbox"/>	25. Sexually transmitted disease
<input type="checkbox"/>	<input type="checkbox"/>	26. Gynecological problems
<input type="checkbox"/>	<input type="checkbox"/>	27. Are you pregnant or could you be pregnant?
YES	NO	LIFESTYLE
<input type="checkbox"/>	<input type="checkbox"/>	28. Do you drink alcohol? If so, drinks per week?
<input type="checkbox"/>	<input type="checkbox"/>	29. Current tobacco use: <input type="checkbox"/> chew <input type="checkbox"/> cigarette <input type="checkbox"/> cigar <input type="checkbox"/> pipe Quantity per day?
<input type="checkbox"/>	<input type="checkbox"/>	30. Currently Employed? Occupation:
<input type="checkbox"/>	<input type="checkbox"/>	31. Weekly Exercise: <input type="checkbox"/> Daily <input type="checkbox"/> 3-5 times <input type="checkbox"/> 1-3 times
<input type="checkbox"/>	<input type="checkbox"/>	32. Any recent unexpected weight loss or gain?

Other health concerns:

FAMILY HEALTH HISTORY

YES	NO	CONDITION	RELATIONSHIP	COMMENTS
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure		
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease		
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes		
<input type="checkbox"/>	<input type="checkbox"/>	Cancer		
<input type="checkbox"/>	<input type="checkbox"/>	Mental/Emotional Illness		
<input type="checkbox"/>	<input type="checkbox"/>	Stomach or Intestinal Illness		
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease		
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism		
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Convulsions		
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis		
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/Blood Clotting problems		
<input type="checkbox"/>	<input type="checkbox"/>	Death under age 50		

I ATTEST THAT THIS MEDICAL INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Student Signature)

(Date)

Health and Wellness Center · Building 19, Room 177 · Phone (413) 755-4230 · Fax (413) 755-6045

Authorization to Release Information to Fieldwork Sites

This form is available online at: www.stcc.edu/healthservices

Name: _____ **STCC ID#:** _____
(please print)

I hereby authorize Springfield Technical Community College (STCC) to release information from my educational records to third-parties (e.g.: another college or university, supervising fieldwork facility, etc.) for the specific purpose of coordinating my fieldwork participation (clinical rotations and off-campus educational training). Such information may include, but is not limited to, the following:

- STCC RamCard I.D. photo or other I.D. Image
- Records of immunity, such as: measles, mumps, rubella, hepatitis B, varicella and tetanus-diphtheria-and-pertussis, and meningitis
- Tuberculosis screening (Mantoux testing and IGRA-testing) Chest x-ray date and result, as well as Positive PPD Questionnaire, if tuberculin test is positive
- Medical Certificate (documentation of physical examination)
- N95 Mask fitting clearance
- Drug Screening clearance
- Background record check clearance: Such checks include data provided by the Massachusetts Department of Criminal Justice Information Services (DCJIS); the Office of Inspector General/General Services Administration (OIG/GSA); the Massachusetts Department of Children and Families (DCF); the Massachusetts Sex Offender Registry Board (SORB); the state and national fingerprint databases; as well as all relevant state and national criminal history, child welfare and sex offender registries, databases and repositories
- Medical licensing and certification clearance
- Health and liability insurance clearance
- Accommodation form where fieldwork site accommodations have been approved by STCC.

I understand that this authorization will be in effect for the duration of my enrollment at STCC, and I have the right to revoke this authorization, or limit the information released, at any time. However, I further understand that should I revoke this authorization, I may not be cleared for fieldwork placement.

For any questions regarding this release of information, please contact the Health and Wellness Center at (413) 755-4230. The signed and dated form must be returned to the Health and Wellness Center in Building 19, Room 177.

I have read the above statements and agree to the same.

(signature)

(date)

Health and Wellness Center · Building 19, Room 177 · Phone (413) 755-4230 · Fax (413) 755-6045

Technical Standards Acknowledgement Form - Early Childhood Education Program

This form is available online at: www.stcc.edu/healthservices

The attached list of Technical Standards has been prepared to assist you in understanding the essential physical and behavioral requirements for participating in and successfully completing the Early Childhood Education program. These standards must be satisfied by all students in all aspects of the program, with or without a reasonable accommodation, including in the classroom, laboratories, and externship.

Please note that you must carefully review these technical standards. Once reviewed, please complete all of the information below and submit it to the **HEALTH AND WELLNESS CENTER BY THE REQUIRED DEADLINE**. If you are an individual with a disability who seeks reasonable accommodation, please contact the Office of Disability Services, Building 19, Room 141, (413)755-4785 for information concerning the College's accommodation process.

Your signature below shall confirm and verify that you have reviewed the program's technical standards and are capable of performing those standards, with or without a reasonable accommodation. Failure to perform the program's essential technical standards shall result in a student's removal from the program.

1. _____
Print your full name

2. _____
Sign your full name

3. _____
Student ID number (found on your acceptance letter)

4. _____
Date of signature

Please return this form to the Health and Wellness Center, Building 19, Room 177.

EARLY CHILDHOOD EDUCATION PROGRAMMATIC TECHNICAL STANDARDS

Early Childhood Educators must demonstrate certain skills and abilities in order to assure the safety of the young children in their care and to provide the best possible learning environment for them. These essential program standards are expected, with or without reasonable accommodations, as part of ECE coursework as well as work in the field, in preparation for a career in Early Childhood Education.

PHYSICAL

ECE students must have:

- the visual and auditory acuity to successfully maintain a safe and dynamic learning environment
- the physical ability to run, bend, stand for extended periods of time, and to have the physical agility to perform tasks at different levels
- the physical strength to lift, move and carry small children

COMMUNICATION

ECE students must have:

- the verbal ability to express themselves effectively to children, colleagues, administrators, parents and families
- the capability to comprehend the thoughts, ideas, and concerns of others
- the skills necessary to communicate clearly and effectively in writing
- the skills necessary to understand written material

COGNITIVE

ECE students must have:

- the ability to problem solve
- critical thinking skills
- an understanding of the importance of decision making and the ability to make judgement calls under extreme circumstances

PROFESSIONAL

ECE students must have:

- the competence to establish positive relationships with colleagues, administrators, parents, and families
- a desire and ability to resolve conflicts and negotiate with others in order to maintain a positive environment
- the sensitivity to realize the importance of confidentiality in all aspects of working in a professional environment