CERTIFICATE OF GOOD HEALTH

This Certificate of Good Health has been requested by the Patient listed below for the purpose of gaining admission to the Neurodiagnostic Technology Institute.

PATIENT INFORMATION

Patient Name: _____

Patient Address: _____

_____

Patient Date of Birth: _____

I have known this patient for the past _____ years / months *(circle one)* and certify that I have examined the patient and found him / her *(circle one)* to be presently in good physical and mental health. This patient is, to the best of my knowledge, able to meet the physical requirements to perform all of the duties of a Neurodiagnostic Technologist, including, but not limited to:

- The ability to walk and stand for long periods of time;
- Average to above-average manual dexterity and hand/eye coordination;
- Good vision and hearing (or correctable to good); and
- The ability to lift 40 lbs.

I am not aware of any diseases or conditions which would prevent the patient from being physically capable of working within a hospital environment.

The patient is / is not *(circle one)* currently pregnant. Pregnant students must also obtain a separate health declaration letter signed by her obstetrician.

PHYSICIAN INFORMATION

Physician's Name: _____

Physician's Address: _____

_____

Physician's Phone Number: _____

_____ _____

Physician's Signature Date

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SENTRY MD

HEALTH AND IMMUNIZATION REQUIREMENTS

Matriculated students must always be current. Do not return these forms to the Institute. Please return forms in an email as one pdf file the https://mysentrymd.com/sentrymd.html#/upload.

PART I-To be completed by the student **Name: (Please Print)** _____ Last, First, Middle	**Student ID #:**_____	**Email Address:**_____
Address: _____ Street Apt. _____ City State Zip	**Date of Birth** ____/____/____ MM DD YYYY	**First Semester of Entry: (enter the year)** Summer_____ Fall_____ Spring_____

The following requirements apply to all matriculated Institute students

Part II- To be completed by your primary care provider or former student health service.

In order to promote and maintain a safe environment at the Neurodiagnostic Technology Institute, the following information is required prior to enrollment in the Institute. Please have the information in Part II completed by your primary care provider, former pediatrician or student health service. **Submit the forms to Sentry MD in an email as one pdf file to https://mysentrymd.com/sentrymd.html#/upload. KEEP A COPY FOR YOUR OWN RECORDS. DO NOT SEND RECORDS TO THE INSTITUTE. RECORDS MUST BE SENT TO Sentry MD.**

Measles, Mumps and Rubella (MMR) Vaccinations (2 doses required): Dose #1 given at age 12-15 months or later and Dose #2 given at age 4-5 years or later and at least one month after first dose. **OR** **Date of positive antibody titers to:**	**1). _____** **Measles: _____** **Mumps: _____** **Rubella: _____**	**2). _____** **Immune____Non-immune_____** **Immune____Non-immune_____** **Immune____Non-immune_____**	
Tetanus, Diptheria, Pertussis (Tdap) –within last 10 years	**Date: _____**		
Dates of Varicella vaccines (given at least 1 month apart): **OR** **Date of positive antibody titer to Varicella:** **OR** **Primary care verification of history of disease** (month and year of disease is required)	**1). _____** _____ **Month/Year: _____**	**2). _____/ OR** **Immune ____Non-immune____**	
Dates of Hepatitis B vaccinations: **OR** **Date of positive surface antibody titer to Hep B:** (must be completed before first day of classes)	1). _____ _____	**2). _____** **Result: Neg____Pos_____**	**3). _____**
Last TB skin test (PPD/Mantoux): (Must be no more than one year old). If PPD is positive, chest x-ray is required After submitting a normal chest x-ray at entry, an annual note from your health care provider that you are symptom free or a repeated normal chest x-ray will satisfy the yearly test required.	**Date: _____** **X-Ray Date:_____**	**Result: _____mm** **Result: Neg_____Pos_____**	
Influenza vaccine:	**Date: _____**		

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Primary Care Provider Signature AND Provider's stamp is required for this form to be accepted

_____

Provider's Signature

Provider Name (printed): _____

Phone Number: (____) _____

PLACE PROVIDER'S STAMP HERE

Students: Be sure to sign the release statement below

I have reviewed this Health and Immunization Requirements form for completeness and agree to release the information provided on the Neurodiagnostic Technology Institute Immunization Transcript to authorized members of the Institute staff and authorized staff of cooperating agencies, as may be required.

Print student name:_____ Date of Birth:_____

Student Signature:_____ Date:_____

The Institute works with Sentry MD, a confidential health information service. Sentry MD maintains and processes all student health history and CPR certification records and monitors compliance with state law requirements. The information may be provided to authorized members of the Institute staff and authorized staff of cooperating agencies as may be required.

Students must send required Health and Immunization Requirements Form directly to:
Upload forms as one pdf to https://mysentrymd.com/sentrymd.html#/upload

Please direct all questions to Sentry MD at unr@sentrymd.com. Please make copies of all health history and CPR certification documents for your own records prior to submitting them to Sentry MD.

New students: Forms must be complete and delivered to Sentry MD.

Current students: Please utilize these forms to update Sentry MD annually. Complete appropriate areas for TB and Influenza annually and Tdap and CPR as needed BEFORE expiration.

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