Dear Student:

Congratulations on your admission to a health program at Middlesex Community College. Now that you have been admitted, we require that you submit a number of health documents before you can start in your program.

Included in the packet of documents you have received either electronically or as paper documents, are step-by-step instructions on how to create an account for and navigate in CastleBranch (https://portal.castlebranch.com/IX00). CastleBranch is an online resource that allows health program students to submit and track their health records with the College.

**Please note:** It is crucial to select the correct program you are admitted to when placing an order on CastleBranch.

Once you have created an account and are ready to submit documents, you will need to upload the following items on the CastleBranch portal (https://login.castlebranch.com/login):

1. The *Required Student Health Records* document with three pages of student health records forms. These forms need to be filled out by your healthcare provider and include a required physical exam, documentation of your immunizations, and documentation of your completed color-blind test.

2. A copy of your CPR Certification

3. A copy of your current health insurance card or proof of current health insurance coverage

If you have any questions, please email us at healthrecords@middlesex.mass.edu.

We wish you success in your health program!
Welcome to myCB

To place your order go to:

https://portal.castlebranch.com/IX00

To place your initial order, you will be prompted to create your secure myCB account. From within myCB, you will be able to:

- View order results
- Upload documents
- Manage requirements
- Place additional orders
- Complete tasks

Please have ready personal identifying information needed for security purposes. The email address you provide will become your username.

Contact Us: 888.914.7279 or servicedesk.cu@castlebranch.com
How to Place an Order on CastleBranch to Fulfill Student Health Records Requirements for MCC’s Nursing and Allied Health Programs

1. Go to: [https://portal.castlebranch.com/IX00](https://portal.castlebranch.com/IX00)
2. Click Place Order
3. Click on the Program you are admitted to (It is crucial to select the correct program you are admitted to when placing an order on CastleBranch)
4. Click on IXxxxx: Compliance Tracker (from the drop down menu under the program name)
5. Check off I have read order instructions and Click on Click to Continue
6. Check off I have read, understand and agree to the Terms and Conditions of Use and Click Continue
7. Fill out your Personal Information – items with asterisks(“”) are required and Click Next
8. Create your Password and Click Create Account
9. Click Next
10. Click Submit
11. Click Next and Click on LOG INTO DASHBOARD (Top Right) OR go to [https://login.castlebranch.com/login](https://login.castlebranch.com/login) to log on to your account
REQUIRED STUDENT HEALTH RECORDS

Health Programs

- Dental Assisting
- Dental Hygiene
- Diagnostic Medical Sonography
- Medical Assisting
- Medical Laboratory Technology
- Nursing
- Radiologic Technology

FALL ADMISSIONS RECORDS DEADLINE: JUNE 1

SPRING ADMISSIONS RECORDS DEADLINE: NOVEMBER 15

Academy of Health Professions

- Phlebotomy

RECORDS DEADLINE: TWO (2) weeks before the first class

Community Ed. & Training

- Nursing Assistant

NOTE: The Academy of Health Professions and Community Education and Training programs are offered in an accelerated format with varying start dates. For this reason, documentation must be received by the Health Records Office at HEALTHRECORDS@middlesex.mass.edu TWO (2) weeks before the first scheduled class meeting.

Supersedes all forms prior to 11/19/20
This information is not used as a requirement for admission to the college. The completed STUDENT HEALTH RECORD is however a requirement for participation at all clinical sites. This form is confidential and will be kept on file at the Health Records Office. Only pertinent information that may be determined as creating special needs in planning the clinical experience will be shared with the program coordinator.

MCC ID# A00

Last Name ___________________________ First ___________________________ DOB ___________________________
Address ___________________________ City ___________________________ State____ Zip_________
Telephone (home) ___________________________ Telephone (cell) ___________________________
MCC E-mail Address___________________________@mail.middlesex.edu
Secondary E-mail Address___________________________

PROGRAM: (check all that apply) □ Fall 20_____ □ Spring 20_____ □ Summer 20_____ □ Day □ Evening
☐ Dental Assisting ☐ Medical Assisting ☐ Nursing Full-Time ☐ Radiologic Technology
☐ Dental Hygiene ☐ Medical Laboratory Technology ☐ Nursing Part-Time
☐ Diagnostic Medical Sonography ☐ Nursing Assistant (CET) ☐ Phlebotomy (AHP)

In case of emergency notify________________________________________________________

Relationship_________________________ Telephone __________________________
Name of Medical Insurance Plan ______________________ COPY of INSURANCE CARD REQUIRED
Health Care Provider Name ___________________________ MD/DO/PA/NP Telephone __________________________

IMPORTANT: Please read and sign.

(1) I understand that it is my responsibility to submit ALL required medical/health records by the date established by my specific Health Program. Additionally, I also understand that failure to submit all required documents may result in being ineligible for participation in clinical rotations, which could ultimately affect my ability to successfully complete my selected health program.

Student Signature ___________________________ Date __________________________

(2) I understand it is my responsibility to notify my clinical instructor within 24 hours if I am in contact with a reportable disease requiring isolation/quarantine, or if I have symptoms/disease, accident, or infirmity that may change my health status, including pregnancy. I also understand that I will be required to provide medical clearance documentation to my program coordinator in order to return to class or the clinical area.

Student Signature ___________________________ Date __________________________
**PLEASE Attach documentation for all immunizations, TB tests, titers, and chest x-rays.**

Name: ________________________________________________

MCC ID# A00______________________

**TB TESTING** *(Required for ALL Health Programs, must be updated annually, and must provide documents to verify results.)*

I have provided the following supporting documents (attached) to meet my TB testing requirements:

Check one: □ 2-step TB/PPD/Mantoux skin test (includes plant date, read date, and results for *EACH* test = 4 visits)
           Step 1: #1 Plant date, read date with result
           Step 2: #2 Plant date, read date with result (1-3 weeks after Step 1)
□ Quantiferon Gold or T-Spot blood test*
□ Chest X-ray within past 5 years

*Positive reactors to skin or blood tests must submit a negative Chest X-Ray report performed within the past 5 years.

**OSHA COLOR DEFICIENCY TESTING:**

Test Name ___________________________ Results □ Pass □ Fail Date ____/____/______

Month Day Year

**REQUIRED IMMUNIZATIONS - Attach documentation. Handwritten dates not accepted.**

**TETANUS/DIPHTHERIA/ACELLULAR PERTUSSIS** *(one lifetime dose after 2006)*

TDAP ____/____/______ and Td (if TDAP date is greater than 10 years) Td ____/____/______

Month Day Year Month Day Year

**MEASLES, MUMPS, RUBELLA (MMR)** *(two doses required)*

#1: *(first dose must be after age 12 months)* ____/____/______ #2: *(must be at least 1 month after dose #1)* ____/____/______

OR

□ Positive blood titers: Rubeola(Measles): ____/____/______ Mumps: ____/____/______ Rubella: ____/____/______ *(attach copy of lab results)*

**HEPATITIS B**

□ Positive anti-HBs (Hepatitis B Surface Antibody) blood titer: ____/____/______ *(attach copy of lab results) * NEW Effective Fall 2018

OR □ Statement of non-seroconversion for vaccine non-responder after total of 6 doses per CDC Guidelines

**VARICELLA** *(two doses or titer required - history of disease not acceptable)*

#1: ____/____/______ #2: ____/____/______

OR □ Positive blood titer: ____/____/______ *(attach copy of lab results)*

**MENINGOCOCCAL (MenACWY)** *(required of full-time students 21 years of age or younger received on or after 16th birthday)*

____/____/______

Month Day Year

* NEW Effective Fall 2018

**SEASONAL FLU VACCINE** *(required each flu season; must be updated annually with current vaccine BEFORE October 1st)*

____/____/______

Month Day Year
Student Name ___________________________________________________________ DOB _______________________

Date of Exam ______________________ Allergies_________________________________________________________________________

Height ___________________________ Weight ______________________ Blood Pressure _______________________________________

CURRENT OR CHRONIC HEALTH PROBLEMS

1. __________________________________________________________________________
2. __________________________________________________________________________
3. __________________________________________________________________________
4. __________________________________________________________________________

To the health care provider: This student has been accepted to a Health Program that may require long hours, occasional strenuous activity and mental alertness. Students will experience a variety of clinical settings, which may require standing or sitting for long periods of time, lifting patients, and responding and moving quickly. We would like the student to have the opportunity for a successful experience. Therefore, as you complete this form, please consider the capability of this student to fully participate and perform the functions required by the program to which he/she has been accepted.

PLEASE COMPLETE THE FOLLOWING:

Is this student physically capable of performing the functions required in a Health Program at this time? ☐ Yes ☐ No

If any limitations or restrictions, please explain and advise:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Health Care Provider (Print name):________________________________________ Date ______________________________

Telephone: ______________________ Fax Number: ____________________________

Health Care Provider Signature ____________________________________________ MD/DO/NP/PA

**PLEASE Attach documentation for all immunizations, TB tests, titers, and chest x-rays.**