DEAR STUDENT:

You have made a choice to enroll in our CNA, HHA, ADN, EMT or Paramedic program.

PRIOR to starting the program, you are required to have a health appraisal. Contracts with the clinical agencies require that all students be documented to be in good health and free from infectious disease.

PHYSICAL EXAMS: Students must use the Ventura College Health History and Physical Exam forms but can have the physical examination and testing done by the Ventura College Student Health Center (cost sheet attached) or the health care provider of your choice.

VC Student Health Center 4667 Telegraph Rd., Ventura (805) 289-6346 (By appointment only)

YOU MUST TAKE THE REQUIRED FORMS WITH YOU. PLEASE COMPLETE THE HEALTH HISTORY FORM BEFORE YOUR PHYSICAL EXAM APPOINTMENT.

BLOOD TESTS AND IMMUNIZATIONS: Students may have blood tests and immunizations done by Ventura College Student Health Center, Ventura County Public Health or through a health care provider of your choice. Blood tests and immunizations through Student Health usually are less expensive than what many health care providers charge.

If available, please bring any immunization records with you, such as: childhood, employment or military. This may reduce your costs and avoid unnecessary lab work and/or vaccinations.

Students must have the following before being assigned to the clinical area:

- Physical examination (valid for 1 year)
- TB clearance (2-Step PPD skin test or QuantiFERON blood test)
- Proof of all required immunizations or provide titers (lab work) demonstrating immunity. Titers are valid for 10 years.

Note: CNA and HHA students must complete the requirements prior to registration in the program.

THERE ARE NO EXCEPTIONS TO THE REQUIREMENTS.

Please make and keep a copy of your physical examination and lab test results for future reference. We are unable to make copies for you.

Rev. 09/10/2015
Health Sciences Medical Clearance Fees*

Pricing as of May 8, 2015

<table>
<thead>
<tr>
<th>Service</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicals</td>
<td>$20.00</td>
</tr>
<tr>
<td>Hepatitis B Vaccines</td>
<td>$32.00 each</td>
</tr>
<tr>
<td>Hepatitis B Lab Work</td>
<td>$6.00</td>
</tr>
<tr>
<td>MMR Vaccine</td>
<td>$50.00</td>
</tr>
<tr>
<td>Measles Lab Work</td>
<td>$4.00</td>
</tr>
<tr>
<td>Mumps Lab Work</td>
<td>$8.00</td>
</tr>
<tr>
<td>Rubella Lab Work</td>
<td>$4.00</td>
</tr>
<tr>
<td>TB Skin Test</td>
<td>$5.00 each</td>
</tr>
<tr>
<td>QuantiFERON Blood Test</td>
<td>$56.00</td>
</tr>
<tr>
<td>Tdap Vaccine</td>
<td>$35.00</td>
</tr>
<tr>
<td>Varicella Lab Work</td>
<td>$5.00</td>
</tr>
</tbody>
</table>

Please call to schedule an appointment (805) 289-6346.

* All prices are subject to change.
Dear Health Care Provider:

The area hospitals are requiring the following for admission into their clinical programs. Please do not make any substitutions.

1. Physical Exam completed using the attached Ventura College form (valid for 1 year).

2. Provider's name printed clearly AND the facility name and address stamped on all medical forms.

3. Tuberculin Skin Test must be the PPD Mantoux only. A copy of the test with date and time given and date and time read must be included with the forms. A 2-Step Method is required (2 skin tests must be completed within 21 days. There must be at least 7 days between Steps 1 and 2), unless there is a history of a positive PPD, then you must complete a Systems Review and QuantiFERON blood test.

4. Students must submit one of the following:
   - Documentation of two (2) MMR immunizations at least four (4) weeks apart
   - OR
   - Documentation of lab work (valid for 10 years) demonstrating immunity of:
     - Rubella Antibody-IGG Lab work
     - Rubeola Antibody-IGG Lab work
     - Mumps Antibody-IGG Lab work

5. Students must submit one of the following:
   - Documentation of two (2) Varicella immunizations at least four (4) weeks apart
   - OR
   - Documentation of lab work (valid for 10 years) demonstrating immunity of:
     - Varicella Antibody-IGG Lab work

6. **Hepatitis B vaccination is highly recommended**, however, if one does not have documentation of the series or documented immunity to Hepatitis B, a declination (waiver) must be signed.

7. Tdap vaccination (valid for 10 years) is required.

8. Current influenza vaccine documentation is required during the flu season.

9. Lab work and/or immunization records, with the individual's name clearly identified, are required for above stated tests.

If you have any questions, please feel free to call Ventura College Student Health Center at (805) 289-6346 or the School of Nursing at (805) 289-6342 or the School of Prehospital and Emergency Medicine (805) 289-6364.

Thank you for your cooperation in this matter.

Rev. 06/09/2015
### PERSONAL HISTORY – Please circle appropriate response

<table>
<thead>
<tr>
<th>HEAD</th>
<th>INFECTIOUS DISEASE (continued)</th>
<th>MUSCULOSKELETAL/NEUROLOGICAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No Major dental problems</td>
<td>Yes No Coccidiomycosis (Valley Fever)</td>
</tr>
<tr>
<td>Yes</td>
<td>No Dizziness/Fainting</td>
<td>Yes No Histoplasmosis</td>
</tr>
<tr>
<td>Yes</td>
<td>No TMJ</td>
<td>Yes No Mononucleosis</td>
</tr>
<tr>
<td>Yes</td>
<td>No Malaria</td>
<td>Yes No Seizure/Convulsions</td>
</tr>
<tr>
<td>Yes</td>
<td>No Eye trouble</td>
<td>Yes No Abdominal pain</td>
</tr>
<tr>
<td>Yes</td>
<td>No Contacts lens</td>
<td>Yes No Recent changes in appetite</td>
</tr>
<tr>
<td>Yes</td>
<td>No Sinusitis</td>
<td>Yes No Recent changes in bowel habits</td>
</tr>
<tr>
<td>Yes</td>
<td>No Color blind</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Gastrointestinal</td>
<td>Yes No Swollen or painful joints or extremities</td>
</tr>
<tr>
<td>Yes</td>
<td>No High blood pressure</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Rapid or irregular pulse</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Chest pain pressure</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Heart disease/Murmur</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Anemia</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Asthma</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Chronic cough</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Emphysema</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Night sweats</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Pneumonia</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Pleurisy</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Wheezing</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Shortness of breath</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Increasing blood pressure</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Venereal disease</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Prior BCG</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Prior positive PPD</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Tuberculosis</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Chicken Pox</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Measles</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Rubella</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Hepatitis</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Encephalitis</td>
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<tr>
<td>Yes</td>
<td>No Meningitis</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Scarlet fever</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Venereal disease</td>
<td>Yes No Malaria</td>
</tr>
<tr>
<td>Yes</td>
<td>No Other</td>
<td>Yes No Malaria</td>
</tr>
</tbody>
</table>

Please explain all YES answers and explain conditions that are not listed above.

---

REV 09/10/2015
### Physical Examination

**Name**

**Ht.**

**Wt.**

**Pulse**

**Resp.**

**BP**

**Vision (uncorrected)**

R: 20/____ L: 20/____ Both: 20/____

**Vision (corrected)**

R: 20/____ L: 20/____ Both: 20/____

**Ishihara’s Test for color deficiency:**

Pass____ Fail____

**Date of last menstrual period**

**Current medications**

---

### General

**HEAD:**

**EYES:**

**EARS:**

**NOSE:**

**MOUTH/THROAT:**

**NECK:**

**LYMPHATICS:**

**CHEST/LUNGS:**

**CARDIOVASCULAR:**

**ABDOMEN:**

**MUSCULOSKELETAL:**

**SKIN:**

**NEUROLOGIC:**

**MENTAL STATUS:**

---

**Any restrictions on physical activity?**

(Explain any restrictions that may prevent the student from participating in the clinical practicum or class)

Yes _____ No_____

---

**Any recommendations for medical care?**

(Explain restrictions and recommendations)

Yes _____ No_____

---

**Does patient have a medical marijuana card?**

Yes _____ No_____

---

**DATE EXAMINED:**

**Health care provider PRINTED NAME:**

**Health care provider SIGNATURE:**

**Health care provider NAME & ADDRESS STAMP**

*(please stamp here)*

**FORM IS INVALID WITHOUT OFFICE STAMP**

Rev. 09/10/2015
VENTURA COLLEGE HEALTH SCIENCES DEPARTMENT TB SCREENING

NAME ___________________________ ID# 900 ___________ DOB ___________

TB SCREENING - A 2-Step (two skin tests) must be completed within 21 days (there must be at least 7 days between Steps 1 and 2).

**TB Mantoux:**
Test #1  Date & Time Administered: __________________ Date & Time Read:__________________

       Neg _____  Pos _____mm Ind _____mm

Test #2  Date & Time Administered: __________________ Date & Time Read:__________________

       Neg _____  Pos _____mm Ind _____mm

If your TB skin test is positive:
You will need to complete a Systems Review form in this packet. You will also be referred for a QuantiFERON blood test and possibly a chest x-ray depending on the results of the Systems Review.

- If the **QuantiFERON is negative**, you will need to return to the health facility that ordered your QuantiFERON for clearance.
- If the **QuantiFERON is positive**, you will be referred to the Ventura County TB clinic.

If you have a history of a positive tuberculin skin test:
You must complete a Systems Review and QuantiFERON blood test within the last year.

If you have a history of a negative QuantiFERON blood test:
You must provide results of a QuantiFERON blood test done within the last year and complete a Systems Review along with any follow-up clinical notes regarding evaluation and treatment.

If you have a history of a positive QuantiFERON blood test:
You must complete an annual Systems Review and provide a copy of the positive result along with any follow-up clinical notes regarding evaluation and treatment.

---

Health care provider PRINTED NAME: ___________________________

Health care provider SIGNATURE: ___________________________

Health care provider NAME & ADDRESS STAMP

(please stamp here)

FORM IS INVALID WITHOUT OFFICE STAMP

Revised 11/10/2015
VENTURA COLLEGE HEALTH SCIENCES DEPARTMENT IMMUNIZATION RECORD

<table>
<thead>
<tr>
<th>NAME</th>
<th>ID# 900</th>
<th>DOB</th>
</tr>
</thead>
</table>

1. **RUBEOLA (Measles), MUMPS, & RUBELLA**
   - Required documentation: 2 MMR vaccinations at least 4 weeks apart OR lab work demonstrating immunity

<table>
<thead>
<tr>
<th>Vaccination date #1</th>
<th>Vaccination date #2</th>
</tr>
</thead>
</table>

   OR

2. **VARICELLA (Chickenpox)**
   - Required documentation: 2 Varicella vaccinations at least 4 weeks apart OR lab work demonstrating immunity

<table>
<thead>
<tr>
<th>Vaccination date #1</th>
<th>Vaccination date #2</th>
</tr>
</thead>
</table>

   OR

3. **HEPATITIS B**
   - Hepatitis B series is strongly advised. Students who do not have documented proof of the series OR lab work documenting immunity, must sign a declination (waiver).

<table>
<thead>
<tr>
<th>Series #1 date</th>
<th>Series #2 date</th>
<th>Series #3 date</th>
</tr>
</thead>
</table>

   OR

4. **RUBEOLA (Measles) (IGG)**
   - Lab work date
   - Lab work results
   - Vaccination date #1
   - Follow-up lab work

   OR

5. **VARICELLA (Chickenpox) (IGG)**
   - Lab work date
   - Lab work results
   - Vaccination date #1
   - Follow-up lab work

   OR

6. **HEP B ANTIBODY LAB WORK: (ANTI-HBS)**
   - Lab work date
   - Lab work results

   OR

5. **TDAP BOOSTER**
   - Need documented proof of Tdap within 10 years: ________________

   OR

7. **MUMPS (IGG)**
   - Lab work date
   - Lab work results
   - Vaccination date #1
   - Follow-up lab work

   OR

8. **RUBELLA (IGG)**
   - Lab work date
   - Lab work results
   - Vaccination date #1
   - Follow-up lab work

   OR

9. **CAIR #**

   FORM IS INVALID WITHOUT OFFICE STAMP

---

Health care provider PRINTED NAME:

Health care provider SIGNATURE:

Health Care Provider NAME & ADDRESS STAMP

(please stamp here)
VENTURA COLLEGE HEALTH SCIENCES DEPARTMENT
SYSTEMS REVIEW FOR TUBERCULOSIS (STUDENT)

USE ONLY FOR POSITIVE TB RESULTS

NAME ___________________________ Telephone # ___________________ Date: ________________

ID # __________________ Date of Birth ______________ Place of birth __________________

QuantiFERON TB blood test date: ______________ Results: __________________
If chest x-ray required, Chest X-Ray date: ______________ Results: __________________

YES  NO
☐  ☐ Cough
☐  ☐ Old TB
☐  ☐ Smoke
☐  ☐ Chest Pains
☐  ☐ Diabetes
☐  ☐ Pregnant
☐  ☐ Hemoptysis
☐  ☐ Ulcers
☐  ☐ Cancer
☐  ☐ Fever

YES  NO
☐  ☐ Hepatitis
☐  ☐ Steroids
☐  ☐ Shortness of breath
☐  ☐ Lung Disease
☐  ☐ Gastric surgery
☐  ☐ Night sweats
☐  ☐ Weight Loss
☐  ☐ Work in penal institution
☐  ☐ Resided or traveled outside of the United States within the past year.

Have you ever taken INH?
☐ YES  ☐ NO

If yes, for how long? ________________

Have you had exposure to anyone with TB?
☐ YES  ☐ NO

No symptoms—student is cleared for participation in health science programs including hospital clinical and field care.

Not cleared for participation in health science program at this time. Referred to TB Clinic. Date: ______________

Cleared to participate in health science program by TB clinic. Date: ______________

Health care provider PRINT NAME: ___________________________

Health care provider SIGNATURE: ___________________________

Health care provider NAME & ADDRESS STAMP

(please stamp here)

FORM IS INVALID WITHOUT OFFICE STAMP

Rev. 2/17/2016
HEPATITIS B VACCINE DECLINATION (WAIVER)

I have been informed and understand that due to my participation in this course and possible exposure to blood and/or other potentially infectious materials that I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been advised, and given the opportunity to be vaccinated for a fee with Hepatitis B vaccination. However, I decline the Hepatitis B vaccination, and understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

Signed: ______________________  Name: ______________________  Date: ________

VERIFICATION OF COMPLETION OF THE HEPATITIS B SERIES WITH PROOF

I have fully completed the Hepatitis B vaccine series and have proof of the three vaccines or lab work demonstrating immunity.

Signed: ______________________  Name: ______________________  Date: ________