VENTURA COLLEGE HEALTH SCIENCES DEPARTMENT
SCHOOL OF NURSING & ALLIED HEALTH
SCHOOL OF PREHOSPITAL AND EMERGENCY MEDICINE

STUDENT PHYSICAL EXAMINATION & IMMUNIZATION REQUIREMENTS

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 (*By appointment only*)	4667 Telegraph Rd., Ventura	(805) 289-6346

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

Ventura College
Student Health Center

Health Sciences Medical Clearance Fees*

Pricing as of May 8, 2015

Physicals	$20.00
Hepatitis B Vaccines	$32.00 each
Hepatitis B Lab Work	$6.00
MMR Vaccine	$50.00
Measles Lab Work	$4.00
Mumps Lab Work	$8.00
Rubella Lab Work	$4.00
TB Skin Test	$5.00 each
QuantiFERON Blood Test	$56.00
Tdap Vaccine	$35.00
Varicella Lab Work	$5.00

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

* All prices are subject to change.

VENTURA COLLEGE HEALTH SCIENCES DEPARTMENT

PHYSICAL EXAMINATION & IMMUNIZATION REQUIREMENTS

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

Year _____ Fall _____Spring _____Summer _____ CNA _____ HHA _____ ADN _____ EMT _____ PM _____

VENTURA COLLEGE HEALTH SCIENCES DEPARTMENT

Health History and Physical Examination

(Please complete before physical examination)

Name _____ Date of Birth _____ Cell Phone # _____

Student I.D. #_____ Sex _____ Home Phone # _____

Allergies _____ Email _____ Date of last menstrual period _____

Medications _____

PERSONAL HISTORY – Please circle appropriate response

HEAD			INFECTIOUS DISEASE (continued)			MUSCULOSKELETAL/NEUROLOGICAL		
Yes	No	Major dental problems	Yes	No	Coccidiodomycosis (Valley Fever)	Yes	No	Seizure/Convulsions
Yes	No	Dizziness/Fainting	Yes	No	Histoplasmosis	Yes	No	Chronic muscle pain
Yes	No	TMJ	Yes	No	Mononucleosis	Yes	No	Vertebrae, disc problems
EYES			Yes	No	Malaria	Yes	No	Swollen or painful joints or extremities
Yes	No	Eye trouble	GASTROINTESTINAL			Yes	No	Bone infections
Yes	No	Wear glasses	Yes	No	Abdominal pain	Yes	No	Amputation
Yes	No	Wear contact lens	Yes	No	Recent changes in appetite	Yes	No	Speech deficit
Yes	No	Color blind	Yes	No	Recent changes in bowel habits	Yes	No	Attention Deficit Disorder
EARS/NOSE/THROAT			Yes	No	Recent constipation	Yes	No	Cluster headaches
Yes	No	Allergies	Yes	No	Frequent diarrhea	Yes	No	Paralysis, tremors, muscle weakness
Yes	No	Hay Fever	Yes	No	Digestive disorder	Yes	No	Neuralgia/numbness
Yes	No	Ear Trouble	Yes	No	Difficulty swallowing	Yes	No	Frequent headaches
Yes	No	Hearing problem	Yes	No	Recurrent vomiting	Yes	No	Migraine
Yes	No	Frequent nose bleeds	Yes	No	Gastric or duodenal ulcers	Yes	No	Arthritis
Yes	No	Sinusitis	Yes	No	Hemorrhoids/Rectal fissures	Yes	No	Periods of unconsciousness
Yes	No	Frequent sore throat	Yes	No	Other ano-rectal disorder	MENTAL HEALTH		
ENDOCRINE			Yes	No	Hernia	Yes	No	Frequent nightmares
Yes	No	Hypothyroid	Yes	No	Intestinal worms	Yes	No	Trouble concentrating
Yes	No	Hyperthyroid	Yes	No	Jaundice	Yes	No	Cry often
Yes	No	Diabetes	Yes	No	Black bowel movements	Yes	No	Feeling of depression
CHEST/HEART/LUNGS/VASCULAR			Yes	No	Vomiting blood	Yes	No	Tendency to worry
Yes	No	Chest pain/pressure	Yes	No	Intestinal inflammation	Yes	No	Memory loss
Yes	No	Heart disease/Murmur	Yes	No	Gall Bladder disease	Yes	No	Mental health disorder
Yes	No	High blood pressure	GENITOURINARY			Yes	No	Considerable nervousness
Yes	No	Rapid or irregular pulse	Yes	No	Blood, albumin, sugar in urine (circle one)	Yes	No	Considerable loneliness
Yes	No	Varicose veins	Yes	No	Kidney disease	Yes	No	Difficulty sleeping
Yes	No	Asthma	Yes	No	Bladder disease	Yes	No	Considered suicide
Yes	No	Chronic cough	Yes	No	Painful urination	Yes	No	Lose temper often
Yes	No	Emphysema	Yes	No	Genital disorders	SOCIAL HISTORY		
Yes	No	Lung diseases	Yes	No	Prostate disorder	Yes	No	Have used narcotics, stimulants, LSD or other hallucinogens more than once
Yes	No	Night sweats	Yes	No	Other			
Yes	No	Pneumonia	FEMALE			Yes	No	Frequent use of alcohol
Yes	No	Pleurisy	Yes	No	Abnormal pap smear	Yes	No	Frequent use of marijuana, if yes
Yes	No	Wheezing	Yes	No	Ovarian cysts	Yes	No	…do you have a medical marijuana card?
Yes	No	Shortness of breath	Yes	No	Pelvic inflammatory disease	Yes	No	Use tranquilizers or sleeping pills frequently
Yes	No	Coughing up blood	Yes	No	Vaginal discharge	Yes	No	Frequent use of designer drugs
INFECTIOUS DISEASE			Yes	No	Vaginal itching	BLOOD DISORDER		
Yes	No	Prior BCG	Yes	No	Pregnancy	Yes	No	Anemia
Yes	No	Prior positive PPD	Yes	No	Infertility	Yes	No	Rheumatic fever
Yes	No	Tuberculosis	Yes	No	Painful menses	Yes	No	Sickle cell
Yes	No	Chicken Pox	Yes	No	Fibrocystic disease	Yes	No	Other
Yes	No	Measles	Yes	No	Breast mass	ADDITIONAL MEDICAL HISTORY		
Yes	No	Mumps	Yes	No	Other	Yes	No	Cancer
Yes	No	Rubella				Yes	No	Unusual fatigue
Yes	No	Hepatitis	SURGICAL HISTORY			Yes	No	Frequent colds
Yes	No	Encephalitis	Yes	No	Appendectomy	Yes	No	Serious illness
Yes	No	Meningitis	Yes	No	Gall bladder	Yes	No	Sexual problems
Yes	No	Scarlet fever	Yes	No	Pelvic surgery	Yes	No	Skin disorder/infections
Yes	No	Venereal disease	Yes	No	Other	Yes	No	Recent gain or loss of weight
						Yes	No	Other

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

_____

_____

_____

VENTURA COLLEGE HEALTH SCIENCES DEPARTMENT

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 _____

_____

	WNL	DETAILED DESCRIPTION OF ABNORMAL FINDINGS
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

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

VENTURA COLLEGE HEALTH SCIENCES DEPARTMENT IMMUNIZATION RECORD

NAME _____ **ID#** **900**_____ **DOB** _____

1. RUBEOLA (Measles), MUMPS, & RUBELLA

Required documentation: 2 MMR vaccinations at least 4 weeks apart OR lab work demonstrating immunity

MMR (Measles, Mumps, Rubella)

Vaccination date #1 _____

Vaccination date #2 _____

OR

RUBEOLA (Measles) (IGG)

Lab work date _____

Lab work results _____

If needed

Vaccination date #1 _____

Follow-up lab work _____

MUMPS (IGG)

Lab work date _____

Lab work results _____

If needed

Vaccination date #1 _____

Follow-up lab work_____

RUBELLA (IGG)

Lab work date _____

Lab work results_____

If needed

Vaccination date #1 _____

Follow-up lab work _____

CAIR # _____

2. VARICELLA (Chickenpox)

Required documentation: 2 Varicella vaccinations at least 4 weeks apart OR lab work demonstrating immunity

VARICELLA

Vaccination date #1 _____

Vaccination date #2 _____

OR

VARICELLA (Chickenpox) (IGG)

Lab work date _____

Lab work results _____

Vaccination date #1 _____

Follow-up lab work _____

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).

HEPATITIS B

Series #1 date _____

Series #2 date _____

Series #3 date _____

OR

HEP B ANTIBODY LAB WORK: (ANTI-HBS)

Lab work date _____

Lab work results _____

5. TDAP BOOSTER

Need documented proof of Tdap within 10 years: _____

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

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		YES	NO	
☐	☐	Cough	☐	☐	Hepatitis
☐	☐	Old TB	☐	☐	Steroids
☐	☐	Smoke	☐	☐	Shortness of breath
☐	☐	Chest Pains	☐	☐	Lung Disease
☐	☐	Diabetes	☐	☐	Gastric surgery
☐	☐	Pregnant	☐	☐	Night sweats
☐	☐	Hemoptysis	☐	☐	Weight Loss
☐	☐	Ulcers	☐	☐	Work in penal institution
☐	☐	Cancer	☐	☐	Resided or traveled outside of the United States within the past year.
☐	☐	Fever			

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

VENTURA COLLEGE HEALTH SCIENCES DEPARTMENT

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:_____