

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 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.

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.

Ventura College

Student Health Center



Health Sciences Medical Clearance Fees*

Pricing as of January 10, 2018

Physicals	\$20.00
Hepatitis B Vaccines	\$39.00 each
Hepatitis B Lab Work	\$ 5.00
MMR Vaccine	\$60.00
Measles Lab Work	\$ 5.00
Mumps Lab Work	\$13.00
Rubella Lab Work	\$ 4.00
TB Skin Test	\$ 6.00 each
QuantiFERON Blood Test	\$50.00
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. TB clearance must be by QuantiFERON blood test or Tuberculin Skin Test. 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 System 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
OR
 - Documentation of lab work (valid for 10 years) demonstrating immunity of:
 - Varicella Antibody-IGG Lab work
6. Students must submit one of the following:
 - 3 doses of the Hepatitis Vaccine, followed by lab work and a titer showing proof of immunity
 - If there is no evidence of immunity a Hepatitis B booster followed by lab work within 30-60 days is required.
 - A declination waiver may be signed. This is not recommended.
7. Tdap vaccination (valid for 10 years) is required.
8. Current influenza vaccine documentation is required during the flu season. You will receive notification when this is required.
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.

11/19/17

VENTURA COLLEGE HEALTH SCIENCES DEPARTMENT

Health History and Physical Examination

(Please complete before physical examination)

Name _____ Preferred Name _____ Date of Birth _____

Student I.D. # _____ Sex _____ Preferred Gender _____ Cell Phone # _____

Allergies _____ Email _____ Home Phone # _____

Medications _____ Date of last menstrual period _____

PERSONAL HISTORY – Please circle appropriate response

HEAD	INFECTIOUS DISEASE (continued)	MUSCULOSKELETAL/NEUROLOGICAL
Yes No Major dental problems	Yes No Coccidioidomycosis (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/h 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 Frequent use of alcohol
Yes No Pneumonia	FEMALE	Yes No Frequent use of marijuana, if yes
Yes No Pleurisy	Yes No Abnormal pap smear	Yes No ...do you have a medical marijuana card?
Yes No Wheezing	Yes No Ovarian cysts	Yes No Use tranquilizers or sleeping pills frequently
Yes No Shortness of breath	Yes No Pelvic inflammatory disease	Yes No Frequent use of designer drugs
Yes No Coughing up blood	Yes No Vaginal discharge	BLOOD DISORDER
INFECTIOUS DISEASE	Yes No Vaginal itching	Yes No Anemia
Yes No Prior BCG	Yes No Pregnancy	
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 _____

➤ The student does not have a health condition that creates a hazard to self or others.

Yes _____ No _____

➤ Does student 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

OR QuantiFERON Blood Test Result = _____

If your TB skin test is positive:

A Systems Review form (in the packet) needs to be filled out and reviewed by a licensed clinician. 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 for possible treatment and further testing before clearance.

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 _____

<p>1. RUBEOLA (Measles), MUMPS, & RUBELLA <i>Required documentation:</i></p> <p><input type="checkbox"/> 2 MMR vaccinations at least 4 weeks apart OR <input type="checkbox"/> lab work demonstrating immunity</p>	<p>2. VARICELLA (Chickenpox) <i>Required documentation:</i></p> <p><input type="checkbox"/> 2 Varicella vaccinations at least 4 weeks apart OR <input type="checkbox"/> lab work demonstrating immunity</p>	<p>3. HEPATITIS B</p> <p><input type="checkbox"/> A Hepatitis B series is strongly advised. Students must have documented proof of the series AND lab work demonstrating immunity. If you do not have proof of immunity, a booster is required with follow up lab work within 30-60 days OR <input type="checkbox"/> Declination Waiver signed</p>
<p>MMR (Measles, Mumps, Rubella) Vaccination date #1 _____ Vaccination date #2 _____</p> <p>RUBEOLA (Measles) (IGG) Lab work date _____ Lab work results _____</p> <p style="border: 1px solid black; padding: 2px; width: fit-content;">If needed</p> <p>Booster date #1 _____ Follow-up lab work _____</p>	<p>VARICELLA Vaccination date #1 _____ Vaccination date #2 _____</p> <p>VARICELLA (Chickenpox) (IGG) Lab work date _____ Lab work results _____</p> <p>Booster date #1 _____ Follow-up lab work _____</p>	<p>HEPATITIS B Series #1 date _____ Series #2 date _____ Series #3 date _____ Booster date _____</p> <p>HEP B ANTIBODY LAB WORK: (ANTI-HBS) Lab work date _____ Lab work results _____</p> <p><i>Lab work to be completed within 30-60 days of the last Hepatitis B vaccination administered.</i></p>
<p>MUMPS (IGG) Lab work date _____ Lab work results _____</p> <p style="border: 1px solid black; padding: 2px; width: fit-content;">If needed</p> <p>Booster date #1 _____ Follow-up lab work _____</p> <p>RUBELLA (IGG) Lab work date _____ Lab work results _____</p> <p style="border: 1px solid black; padding: 2px; width: fit-content;">If needed</p> <p>Booster date #1 _____ Follow-up lab work _____</p>	<p>Health care provider PRINTED NAME: _____</p> <p>Health care provider SIGNATURE: _____</p> <p style="text-align: center;">Health Care Provider NAME & ADDRESS STAMP</p> <p style="text-align: center;">(please stamp here) FORM IS INVALID WITHOUT OFFICE STAMP</p>	
<p>CAIR # _____</p>	<p>Rev. 11/19/17</p>	

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 am at risk of acquiring Hepatitis B virus (HBV). I have been advised, and given the opportunity to be immunized for a fee with Hepatitis B vaccination and screened for immunity to Hep B. However, I decline the Hepatitis B vaccination and screening, and understand that by declining, I continue to be at risk of acquiring Hepatitis B, which is known to be a serious disease.

Signed: _____ Name: _____ Date: _____

VERIFICATION OF COMPLETION OF THE HEPATITIS B SERIES WITH PROOF

I have fully completed the Hepatitis B requirements.

Signed: _____ Name: _____ Date: _____