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 and 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 are usually 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 [TB PPD skin test (TST) or QuantiFERON blood test]
- Proof of all required immunizations or provide titers (quantitative lab work) demonstrating immunity.

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. 8/14/19

Ventura College

Student Health Center

Health Sciences Medical Clearance Fees*

Pricing as of July 23, 2019

Physicals	$20.00
Hepatitis B Vaccines	$44.00 each
Hepatitis B Lab Work	$ 5.00
MMR Vaccine	$10.00
Measles Lab Work	$ 5.00
Mumps Lab Work	$13.00
Rubella Lab Work	$ 4.00
TB Skin Test	$ 8.00 each
QuantiFERON Blood Test	$49.00
Tdap Vaccine	$35.00
Varicella Lab Work	$ 5.00
Varicella Vaccine	$100.00
Flu Vaccine	$20.00

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

*All prices are subject to change. **We do not bill insurance. All fees will be posted to your student account.**

Rev. 8/14/19 BBe/MJones

VENTURA COLLEGE HEALTH SCIENCES DEPARTMENT

PHYSICAL EXAMINATION & IMMUNIZATION REQUIREMENTS

Dear Health Care Provider:
The area hospitals require 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 (TST). 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). If there is a history of a positive TST and QFT with a negative CXR then only a system review is required annually.**

4. Students must submit one of the following:
   - Documentation of two (2) MMR immunizations at least four (4) weeks apart
     OR
   - Documentation of quantitative lab work 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 quantitative lab work demonstrating immunity of:
     - ☐ Varicella Antibody-IGG Lab work

6. Students must submit the following:
   - Tdap vaccination (valid for 10 years)
   - Current influenza vaccine documentation is required during the flu season. Flu documentation must include serum manufacturer, lot#, provider & date. **You will receive notification when this is required, after the fall semester of school starts. For spring semester, it is a requirement upon admission.**
   - Quantitative lab work and/or immunization records, with the individual's name clearly identified, are required for the aforementioned vaccines and labs.

7. For your protection, completion of a 3-dose Hep B vaccine series or 2-dose (HEPLISAV-B) vaccine series with a positive quantitative titer is recommended.
   - A declination waiver must be signed if the aforementioned recommendation is not completed.

If you have any questions, please feel free to call Ventura College Student Health Center at (805) 289-6346, 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.

8/14/19

Year __________ Fall _____ Spring _____ Summer _____ CNA _____ HHA _____ ADN _____ EMT _____ PM _____

VENTURA COLLEGE HEALTH SCIENCES DEPARTMENT
Health History and Physical Examination (page 1 of 2)

(Please complete before physical examination.)

Name ______________________________ Preferred Name ____________________ Date of Birth ______________________
Student I.D. #900 - ____________________ Sex ________ Preferred Gender________ Cell Phone #______________________
Allergies ____________________________ Email ______________________________ Home Phone #_____________________
Medications ____ Today's Date______________________

PERSONAL MEDICAL HISTORY – Please check if you currently have or have had any of the following conditions:

☐ Anemia ☐ Asthma ☐ Diabetes

☐ Heart Trouble ☐ High Blood Pressure ☐ Cancer

☐ Hepatitis ☐ Liver Trouble ☐ Ulcers or other gastrointestinal disorders

☐ Pneumonia ☐ Rheumatic Fever ☐ Tuberculosis (TB)

☐ Stroke or blood clots ☐ Depression (feeling down or blue) ☐ Thyroid condition

☐ Skin problems ☐ Anxiety (nerves, panic attacks) ☐ Abnormal Pap smears

☐ Seizures ☐ Suicidal thoughts or attempts ☐ Irregular periods

☐ PMS ☐ Tobacco Use ☐ Bleeding between periods

☐ Alcohol Use ☐ Use of marijuana products ☐ STI (syphilis, gonorrhea, chlamydia, HIV)

☐ Drug use (heroin, stimulants, inhalants, prescription opioids) ☐ Pregnant? _______yes _______no

☐ List any history of surgical procedures: (If yes, please notify VC Nursing Dept. for additional clearance forms.)

____

____

☐ List any other medical or mental health conditions not listed above:

____

____

FAMILY HISTORY – Please check if your parents or siblings have had any of the following conditions:

☐ Cancer ☐ Diabetes

☐ Heart Attack ☐ High Blood Pressure

☐ Stroke ☐ Mental Illness

VENTURA COLLEGE HEALTH SCIENCES DEPARTMENT

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 is free of health conditions that creates a hazard to self or others.
  Yes _____ No_____

- Does student use any marijuana products?
  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 clearance is valid for 1 year AND cannot expire before the end of the semester. *****

A 2-Step TB skin test (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 Date: _____________ Result:___________

Hx of positive TB skin test: _____yes _____no Lab form is also required.

If your TB skin test is positive:

A licensed professional needs to complete a Systems Review form (in your packet).

A QuantiFERON-TB lab test needs to be ordered and you may be referred for a chest X-ray.

- If the QuantiFERON-TB test is negative, and your systems review is normal, you will be cleared to participate in the program.
- If the QuantiFERON-TB is positive, a chest X-ray is required and you will be referred for possible treatment and further testing before clearance.

If you have a history of a positive TB skin test without a QuantiFERON-TB lab test:

A Systems Review and QuantiFERON-TB lab test within the last year is required. It must not expire before end of semester.

If you have a history of a positive TB skin test with a negative QuantiFERON blood test:

Provide results of a QuantiFERON-TB blood test done within the last year. It must not expire before end of semester.

If you have a history of a positive TB skin test, a positive QuantiFERON blood test and/or treatment for TB disease or latent TB infection:

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
- ☐ ***Quantitative Lab work demonstrating immunity***

If lab work is negative, documentation of 2 MMR vaccinations must be completed.

MMR (Measles, Mumps, Rubella)

Vaccination date #1 ____________

Vaccination date #2 ____________

RUBEOLA (Measles) (IGG)

Lab work date ______________

Lab work results ______________

MUMPS (IGG)

Lab work date ______________

Lab work results ______________

RUBELLA (IGG)

Lab work date ______________

Lab work results______________

FLU VACCINE

Vaccine date ______________

Lot # ____________________

Manufacturer ______________

Facility where given __________

____

CAIR # ______________________

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2. VARICELLA (Chickenpox)

Required documentation:

- ☐ ***2 Varicella vaccinations at least 4 weeks apart***

  OR
- ☐ ***Quantitative Lab work demonstrating immunity***

If lab work is negative, documentation of 2 Varicella vaccinations must be completed.

VARICELLA

Vaccination date #1 ___________

Vaccination date #2 ___________

VARICELLA (Chickenpox) (IGG)

Lab work date ______________

Lab work results ____________

3. HEPATITIS B

- ☐ ***A Hepatitis B series is strongly advised. Students must have documented proof of the series AND quantitative 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
- ☐ ***Declination Waiver signed***

HEPATITIS B

☐ 3-dose series OR ☐ 2-dose Heplisav-B

Series #1 date ____________________

Series #2 date ____________________

Series #3 date ____________________

Booster date ____________________

HEP B ANTIBODY LAB WORK: (ANTI-HBS)

Lab work date ___________________

Lab work results ___________________

Lab work to be completed within 30-60 days of the last Hepatitis B vaccination administered.

4. 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

VENTURA COLLEGE HEALTH SCIENCES DEPARTMENT

SYSTEMS REVIEW FOR TUBERCULOSIS

NAME ______________________________ **Telephone #** _________________ **Date** ________________

ID # 900_________________ **Date of Birth** ____________ **Country of Birth**______________________

History of Positive TB skin Test:	☐ No	☐ Yes Date: ______________
History of positive QuantiFERON TB blood test	☐ No	☐ Yes Date: ______________
Last chest x-ray (if needed) Date: _____________		Results: ____________________

Please select the following that apply:

□ Treated for TB disease Treatment start and completion date: __________________________

□ Treated for latent TB infection Treatment start and completion date: __________________________

□ Exposure to anyone with TB Date of exposure: ____

□ Under Treatment with an immunosuppressant or have an immune compromising illness

Name of illness or medication: ______________________________________

Have you had any of the following symptoms for $\geq$3 weeks? (Check all that apply.)

□ Cough (unrelated to known illness)

□ Chest pain and/or shortness of breath

□ Changes in sputum (blood, color, thickness)

□ Unexplained weight loss

□ Night sweats

□ Increased fatigue

□ Loss of appetite

□ Chills

□ Fever

☐ Patient is NOT cleared at this time. **Date**: ________________

Referred ☐QFT **Date**: __________________ ☐ CXR **Date**: ________________

☐ TB clinic/PCP **Date**: ____________________

Patient is cleared of TB disease. **Date**: ________________ __________________

Health care provider PRINT NAME:

____

Health care provider SIGNATURE:

____

Health care provider NAME & ADDRESS STAMP

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VENTURA COLLEGE HEALTH SCIENCES DEPARTMENT

Name: ________________________ 900# ______________ DOB: ____________

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 Hepatitis 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:________________________________ Date:_____________

This will satisfy the requirement on CastleBranch however, we strongly recommend you complete the series.