VENTURA COLLEGE

STUDENT PHYSICAL EXAMINATION & IMMUNIZATION REQUIREMENTS

Dear Student:

You have made a choice to enroll in our Police Science Program (POSC V01, POSC N101, POSC V01A, and POSC N101A).

PRIOR to starting the program, you are required to have a health appraisal. This program requires that all students be documented to be in ***good health and drug free.***

1. **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 or by their private physician. The costs can vary depending upon where you have the services performed, but are generally much less expensive at the VC Student Health Center. Costs can range from ***approximately*** $70 at the Student Health Center to around $200 at a private office.*

   VC Student Health Center   4667 Telegraph Rd., Ventura   (805) 289-6346
   (*By appointment only. You must be a Ventura College student and have a 900# prior to making an appointment. See Academy Application Instructions for more information.*)

2. **DRUG SCREEN:** Students must have a drug screen performed. You may complete this test at the VC Student Health Center or through a private physician.

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

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.

* All costs are approximate.

Rev. 01-15-21

Year _________ Fall _____Spring _____Summer _____

VENTURA COLLEGE POLICE SCIENCE (POSC)

Health History and Physical Examination

(Please complete before physical examination)

Name:_________________________Preferred Name_____________________Date of Birth:_______________

Student ID #900__________________Sex_____Preferred Gender_________Cell Phone # _____________________

Allergies_______________Email_____________________________Home Phone #_____________________

Medications____Date of last menstrual period________

PERSONAL HISTORY – Please check or circle any of the following that you have or have had:

HEAD	**INFECTIOUS DISEASE (continued)**	**SURGICAL HISTORY (continued)**
Major Dental Problems	Coccidiodomycosis (Valley fever)	Pelvic surgery
Dizziness / Fainting	Histoplasmosis	Other
TMJ	Mononucleosis	**MUSCULOSKELATAL / NEUROLOGICAL**
EYES	Malaria	Seizure / Convulsions
Eye Trouble	Meningitis	Chronic muscle pain
Wear Glasses	**GASTROINTESTINAL**	Vertebrae – disc problems
Wear contact lenses	Abdominal Pain	Swollen - painful joints / extremities
Color Blind	Recent Changes in appetite	Bone infections
EARS/NOSE/THROAT	Recent changes in bowel habits	Amputation
Allergies	Recent constipation	Speech Deficit
Hay Fever	Frequent diarrhea	Attention Deficit Disorder
Ear Trouble	Digestive disorder	Cluster headaches
Hearing problem	Difficulty swallowing	Paralysis, tremors, muscle weakness
Frequent nose bleeds	Recurrent vomiting	Neuralgia / numbness
Sinusitis	Gastric or duodenal ulcer	Frequent headaches
Frequent Sore Throat	Hemorrhoids / Rectal fissures	Migraine
ENDOCRINE	Other ano-rectal disorder	Arthritis
Hypothyroid	Hernia	Periods of unconsciousness
Hyperthyroid	Intestinal worms	**MENTAL HEALTH**
Diabetes	Jaundice	Frequent Nightmares
CHEST/HEART/LUNGS/VASCULAR	Black bowel movements	Trouble concentrating
Chest pain / pressure	Vomiting blood	Cry often
Heart Disease / Murmur	Intestinal inflammation	Feeling of depression
High Blood Pressure	Gallbladder Disease	Tendency to worry
Rapid or irregular pulse	**GENITOURINARY**	Memory Loss
Varicose veins	Blood, albumin, sugar in urine	Mental health disorder
Asthma	Kidney disease	Considerable nervousness
Chronic Cough	Bladder disease	Considerable loneliness
Emphysema	Painful urination	Difficulty sleeping
Lung Diseases	Genital disorders	Considered Suicide
Night sweats	Prostate disorder	Lose temper often
Pneumonia	Other	**SOCIAL HISTORY**
Pleurisy	**FEMALE**	Have used narcotics, stimulants, LSD, or other hallucinogens more than once
Wheezing	Abnormal pap smear	Frequent use of alcohol
Shortness of Breath	Ovarian cysts	Frequent use of marijuana – if yes
Coughing up blood	Pelvic inflammatory disease	..do you have a medical marijuana card?
INFECTIOUS DISEASE	Vaginal discharge	Use tranquilizers or sleeping pills frequently
Prior BCG	Vaginal itching	Frequent use of designer drugs
Prior Positive PPD	Pregnancy	**BLOOD DISORDER**
Tuberculosis	Infertility	Anemia
Chicken Pox	Painful menses	Rheumatic Fever
Measles	Fibrocystic Disease	Sickle Cell
Mumps	Breast mass	**ADDITIONAL MEDICAL HISTORY**
Rubella	Other	Cancer Unusual fatigue
Hepatitis	**SURGICAL HISTORY**	Frequent colds Serious illness
Encephalitis	Appendectomy	Sexual problems Skin disorder / infection
Scarlet Fever	Gallbladder	Recent gain of loss of weight Other

Please explain all items that you have checked above ______________________________________

VENTURA COLLEGE POLICE SCIENCE (POSC)

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_____

- Patient's drug screen is negative for drug use.
  Yes _____ No_____ (If no, please explain below.)

  ____

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  ____

DATE EXAMINED: ______________________

Health care provider <u>PRINTED NAME</u>:

____

Health care provider <u>SIGNATURE</u>:

____

Health care provider <u>NAME & ADDRESS STAMP</u>

(please stamp here)

FORM IS INVALID WITHOUT OFFICE STAMP