NURSING AND HEALTH OCCUPATION PROGRAMS

TO BE COMPLETED BY STUDENT: **Statement of Health and Immunization Records** (pages 1 & 2)

Student's Name: _____ Birth date: _____
Last First Middle Month/Day/Year

Address: _____
Street City, State Zip Code

Telephone: (_____) _____ E-mail address: _____

DISCLOSURE AND CERTIFICATION STATEMENTS

I hereby grant permission for the release and/or disclosure of health history and health screening medical information between and among authorized college, clinical facilities, and hospital personnel.

CONSENT FOR RELEASE OF HEALTH REPORT, RECORDS AND/OR MEDICAL INFORMATION

I realize the various health agencies where Health Profession students gain experience may wish for students to be certified in good health. I hereby consent to the communication of my health record from Southwestern College to participating agencies as requested.

Furthermore, I acknowledge it is my responsibility to keep current at all times and provide the following to SWC Nursing & Health Occupation Programs Office: a copy of my immunization records, annual physical exam dated within one year, proof of TB clearance dated within one year (unless positive; chest X-Ray report is good for five years), titers (if applicable), seasonal flu shot, CPR certification and/or other medical requirements. Note: the only CPR card accepted is AHA Healthcare Provider or Basic Life Support [BLS] Provider.

Once admitted into the Nursing or Health Occupation Program, I will be required to submit a copy of all current records to the Nursing Office. Students in the ADN, LVN to ADN Step Up, IDC Step Up, VN or Surgical Tech Program must upload records to the Complio online immunization tracking system. The online immunization tracking system does not apply to CNA, Acute Care CNA, Central Service Technology or Operating Room Nurse Programs.

_____ _____ _____
Student Signature Date SWC ID#

NURSING AND HEALTH OCCUPATION PROGRAMS

HEALTH HISTORY FORM

Health History – TO BE COMPLETED BY STUDENT	CHECK "YES" or "NO"	
1. Have you ever been hospitalized? If yes, provide information below.	Yes	No
a. List health problem:	Date:	
b. List operation(s) performed:	Date(s):	
2. Are you under a physician's care now? If yes, provide information below.	Yes	No
a. List name of physician:		
b. List name of health problems:		
c. Are you taking medications on a regular or frequent basis?	Yes	No
If yes, list meds (attach sheet, if needed):		
3. Do you have any allergies?	Yes	No
a. List medications you are allergic to:		
b. List other allergies: (food, pollen, contact, animal, dust):		
4. Have you had a back, neck or wrist injury?	Yes	No
a. Was medical attention or surgery required?	Yes	No
Please explain:		
5. Have you had an injury to any muscle, bone, ligament or tendon?	Yes	No
a. Was medical attention or surgery required?	Yes	No
Please explain:		
5. Do you smoke? If yes, packs per day =	Yes	No
For questions 6-8 below: if you answer "yes," please explain your limitations on a separate sheet of paper.		
6. Do you have any limitations which may affect your ability to lift, turn, or transfer patients? Or otherwise restrict you from participating fully in the RN training program?	Yes	No
7. Do you have any limitation in your use of your senses, such as sight or hearing, which would limit your ability to practice a health profession?	Yes	No
8. Do you have any condition which might interfere with your ability to practice a health profession safely?	Yes	No
PLEASE INDICATE WITH A CHECK IF YOU OR A FAMILY MEMBER HAVE HAD:	SELF	FAMILY MEMBER
a. Hypertension (High blood pressure)		
b. Heart disease		
c. Diabetes		
d. Cancer		
e. Tuberculosis		
f. Seizure disorder		
g. Asthma		
h. Chickenpox		
i. Drug and/or alcohol abuse		

Student Signature _____ Date _____ SWC ID# _____

NURSING AND HEALTH OCCUPATION PROGRAMS

Supplemental Medical Guidelines

TO BE COMPLETED BY PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTIONER:

Nursing students must be able to do total patient care in all nursing areas without physical, emotional, cognitive or psychological limitations. Female students must be able to provide care to male patients and male students must be able to provide care to female patients. Written documentation of complete recovery from any previous injury and/or illness must be provided. Following is a brief description of some of the types of activities that students will perform while working with patients in the hospital. Students are expected to meet all of these parameters.

Note: Any issues regarding disabilities (temporary or permanent) will be reviewed per ADA Act 1990 and reasonable accommodations will be considered per regulation.

1. Moderate to heavy lifting and carrying (20-40 pounds).
2. Pushing, pulling, bending, and kneeling around patients using various types of hospital equipment such as wheelchairs, gurneys, lifting devices and specialized beds; work in small confined spaces, move around rapidly.
3. Fine motor dexterity using both hands while preparing medications and manipulating a variety of instruments and assessment devices.
4. Rapid mental processing and simultaneous motor coordination; necessary to manipulate syringes, start IV's; assist with patient ADL's; write/type; perform procedures.
5. Extensive periods of walking and standing (4 or more hours at one time).
6. Visual discrimination including depth perception and color vision; vision sufficient to make physical assessments of patients and equipment; perform procedures.
7. Ability to hear the spoken word in settings where other sounds are present. Able to hear clearly on the telephone, hear through a stethoscope (sound enhanced OK), to hear cries for help, to hear alarms on equipment and emergency signals and various overhead pages.
8. Working with hands in water (frequent hand washing is required); ability to palpate superficially and deeply; discriminate tactile sensations.
9. Working with various materials and substances to which some individuals may be allergic (such as latex).
10. Ability to speak clearly in order to communicate with patients, families, staff, physicians; need to be understood on the telephone.
11. Have sufficient emotional stability to perform under stress (both academically and in clinical setting).
12. Ability to communicate effectively in English both verbally and in the written format for the classroom setting and the clinical setting.

Note: Casts, splints, braces are not allowed in the clinical setting.

Mark the appropriate box below:

☐ After reviewing the "Supplemental Medical Guidelines" listed above and based on findings from the patient's history and physical exam, I certify that the above student is physically and mentally capable of fully participating in Southwestern College Nursing and Health Occupation Programs.

☐ The following health problems(s) should be further evaluated PRIOR to participation in a clinical assignment:

_____

_____
Examiner's Signature & Title

_____ _____
Physical Exam Date License # (required)

Business Card or facility stamp must accompany this form.

The statement below is to be reviewed and signed by student:

I understand these physical and other requirements for the Nursing Program as specified above. I will inform my healthcare provider, faculty, and the Program Director of any/ all disability issues immediately as they occur, and upon acceptance into the program. *If applicable,* I will make an appointment with Disability Services with any concerns or disability issues.

Student Signature: _____ Date: _____ SWC ID#: _____

NURSING AND HEALTH OCCUPATION PROGRAMS

TO BE COMPLETED BY PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTIONER: Southwestern College requires a physical examination for students enrolling in Nursing and Health Occupation Programs. A statement of your knowledge of this student's health (mental and physical) will be greatly appreciated. This report goes directly to the Nursing Education Department and will be released only to authorized college, clinical facilities and hospital personnel.

STUDENT'S NAME_____
(PRINT) *Last* *First* *Middle Initial*

BP_____ P_____ R_____ Ht._____ Wt._____

	Normal	Abnormal		
Vision:	_____	_____	R.Eye 20/	L.Eye 20/
			Glasses ☐ Yes ☐ No	C/Lens ☐ Yes ☐ No
Hearing:	_____	_____		

If Abnormal, please complete the following decibel information.

	R. Ear	L. Ear
500 hz	_____dcb	_____dcb
1000hz	_____dcb	_____dcb
2000hz	_____dcb	_____dcb

PHYSICAL EXAM:

	Normal	Abnormal	Description:
1. General Appearance	_____	_____	_____
2. Skin	_____	_____	_____
3. Nodes	_____	_____	_____
4. Skull	_____	_____	_____
5. Ears	_____	_____	_____
6. Eyes	_____	_____	_____
7. Nose	_____	_____	_____
8. Oropharynx	_____	_____	_____
9. Dental	_____	_____	_____
10. Neck & Thyroid	_____	_____	_____
11. Chest	_____	_____	_____
12. Cardiovascular	_____	_____	_____
13. Abdomen	_____	_____	_____
14. Hernia Check	_____	_____	_____
15. Musculoskeletal	_____	_____	_____
a. Neck	_____	_____	_____
b. Back	_____	_____	_____
c. Shoulders	_____	_____	_____
d. Knee	_____	_____	_____
e. Ankle	_____	_____	_____
f. Feet	_____	_____	_____
g. Other	_____	_____	_____
Neurological	_____	_____	_____

Comments: _____

_____

NURSING AND HEALTH OCCUPATION PROGRAMS

IMMUNIZATION REQUIREMENTS

To be cleared by Southwestern College Nursing and Health Occupation Programs Office, this form must be completed, signed, and stamped by a Physician, Physician Assistant, Nurse Practitioner, Registered Nurse, Vocational Nurse or Southwestern College Health Services Nurse. A copy of immunization card/records, and/or titers (lab results) must be included with this form for any vaccine or titer given.

NAME: _____ STUDENT ID#: _____
Last *First* *Middle*

MMR (Measles, Mumps, Rubella) vaccine	Date #1: _____	Signature: _____	STAMP HERE
OR	Date #2: _____	Signature: _____	
Titers	Titer	Signature: _____	
Measles ☐ Immune ☐ Not Immune	Date: _____		
Mumps ☐ Immune ☐ Not Immune	Titer Date: _____	Signature: _____	
Rubella ☐ Immune ☐ Not Immune	Titer Date: _____	Signature: _____	
If born *before* January 1, 1957 only 1 dose of MMR or titer immunity is required. If born *after* January 1, 1957 two doses of vaccine or titer is required.			

Hepatitis B vaccine	Date #1: _____	Signature: _____	STAMP HERE
OR	Date #2: _____	Signature: _____	
	Date #3: _____	Signature: _____	
Titer ☐ Immune ☐ Not Immune	Titer Date: _____	Signature: _____	

Varicella (Chickenpox) vaccine	Date #1: _____	Signature: _____	STAMP HERE
OR	Date #2: _____	Signature: _____	
Titer ☐ Immune ☐ Not Immune	Titer Date: _____	Signature: _____	

Tetanus/ Diphtheria and Acellular Pertussis (TDAP) vaccine *Must be within 10 years*	Date #1: _____	Signature: _____	STAMP HERE

Influenza/Flu vaccine (current seasonal shot using Consortium form attached-pg 7)	Date #1: _____	Signature: _____	STAMP HERE

NURSING AND HEALTH OCCUPATION PROGRAMS

MANTOUX TUBERCULIN SKIN TEST REQUIREMENTS

NAME: _____ STUDENT ID#: _____
Last *First* *Middle*

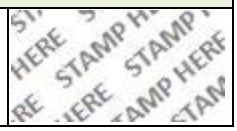
All Health Profession students are required to have a 2-Step INTRADERMAL TST (MANTOUX) prior to starting program, unless previously positive. A TB Test or Questionnaire is due yearly for all students and must be cleared by students' healthcare provider. If TB test is positive, a chest x-ray is required. Chest x-ray results must be dated within five years.

To be cleared by Southwestern College Nursing & Health Occupation Programs, supporting TB documentation results must accompany this form such as Quantiferon TB (blood test), and/or a copy of chest x-ray, if applicable. The size of indurations must be measured in mm.

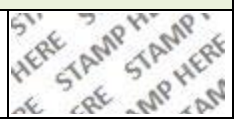
On this form, a signature and stamp will only be accepted from the following: Physician, Physician Assistant, Nurse Practitioner, Registered Nurse, Vocational Nurse or Southwestern College Health Services Nurse.

Step #1 (First PPD Test)		
Date: _____ Time Given: _____	Manufacturer: _____ Dose: 0.1mL Exp. Date: _____ Lot#: _____ Given By:	
Date: _____ Time Read: _____	Results: _____mm Read By:	
Step #2 (Second PPD Test, 7-21 days after Step #1)		
Date: _____ Time Given: _____	Manufacturer: _____ Dose: 0.1mL Exp. Date: _____ Lot#: _____ Given By:	
Date: _____ Time Read: _____	Results: _____mm Read By:	

OR

Chest X-Ray (Only if Mantoux positive, Chest X-Ray required)		
Chest X-Ray Date: _____ (must be within five years)	☐ Negative ☐ Positive (A copy of the chest X-Ray report must be submitted with this form)	

OR

Quantiferon TB		
Date: _____	☐ Negative Positive (A copy of the lab report must be submitted with this form)	

SOUTHWESTERN COLLEGE NURSING AND HEALTH OCCUPATION PROGRAMS

San Diego Nursing Service-Education Consortium

2016-2017 Influenza Vaccination Consent

All students/faculty with clinical assignments must comply with the CDC's recommendations for seasonal flu immunization

The following information is taken from the following website: http://www.cdc.gov/flu/about/season/flu-season-2016-2017.htm. **This season, only injectable flu vaccines (flu shots) should be used.** Some flu shots protect against three flu viruses and some protect against four flu viruses. For 2016-2017, three-component vaccines are recommended to contain: A/California/7/2009 (H1N1) pdm09-like virus, A/Hong Kong/4801/2014 (H3N2)-like virus and a B/Brisbane/60/2008-like virus (B/Victoria lineage). Four component vaccines are recommended to include the same three viruses above, plus an additional B virus called B/Phuket/3073/2013-like virus (B/Yamagata lineage). **The recommendations for people with egg allergies have been updated for this season.** People who have experienced only hives after exposure to egg can get any licensed flu vaccine that is otherwise appropriate for their age and health. People who have symptoms other than hives after exposure to eggs, such as angioedema, respiratory distress, lightheadedness, or recurrent emesis; or who have needed epinephrine or another emergency medical intervention, also can get any licensed flu vaccine that is otherwise appropriate for their age and health, but the vaccine should be given in a medical setting and be supervised by a health care provider who is able to recognize and manage severe allergic conditions. (Settings include hospitals, clinics, health departments, and physician offices). People with egg allergies no longer have to wait 30 minutes after receiving their vaccine. *Please answer the following questions. It is recommended you wait at least 30 minutes after the injection, due to the possibility of an allergic reaction.*

	Question	Yes	No
1.	Is this the first "Flu" vaccination you have ever received?	☐	☐
2.	Have you ever had an allergic or serious reaction to the following; Flu vaccine, chicken eggs, or chicken products, Thimerosal, or have you had Guillain-Barre Syndrome (GBS)?	☐	☐
3.	Are you ill today?	☐	☐
4.	Do you take blood thinners such as Aspirin, Clopidogrel (Plavix), Dipyridamole (Aggrenox), or Coumadin (Warfarin) on a daily basis?	☐	☐
5	Are you under 18 years of age? ***If yes, parental consent is required***.	☐	☐
6.	Are you pregnant? If yes, you must provide written permission from your physician.	☐	☐

Please check your appropriate age group:

Age: 6-18 ☐ 19-49 ☐ 50-59 ☐ 60-64 ☐ Over 65 ☐

Please check your appropriate category: ☐ Student ☐ Faculty

ID #: ____**Telephone**: ___________________

I have read the CDC 2016-2017 Influenza vaccine information statement. By signing below I understand and consent to receive the vaccine.

Name: ____________________________ **Signature**: _____________________________ **Date**: ______________
(Print)

✦✦

Manufacturer**:** _____________________ Lot #:______________________Exp Date: _____________________

Route: IM Site: ☐ R Deltoid ☐ L Deltoid FluMist ___________

Influenza Vaccine 2016-2017 Staff Signature _________________________________ Date _______________