

SOUTHWESTERN COLLEGE NURSING AND HEALTH OCCUPATIONAL PROGRAMS

TO BE COMPLETED BY THE STUDENT:

Disclosure and Release of Health History and Immunization Requirements

Student's Name:		Birth date:		
Last	First	Middle	Month/Day/Year	
Address:				
Street	City,	State	Zip Code	
Telephone: ()	*SWC e-mail address * <u>all</u> program comm	(primary): unications will be v	ia SWC e-mail	
	Secondary e-mail add	lress:		
DISCLOSURE AND CERTIFICATION I hereby grant permission for the release between and among authorized college	lease and/or disclosure of health		screening medical information	
CONSENT FOR RELEASE OF HEAL	TH REPORT, RECORDS AND/O	R MEDICAL INFORM	MATION	
I realize the various health agencies we in good health. I hereby consent to agencies as requested.		-		
Furthermore, I acknowledge it is my r Health Occupation Programs Office: a of TB clearance dated within one ye seasonal flu shot, CPR certification Healthcare Provider or Basic Life Supp	ar (unless positive; chest X-Ray and/or other medical requireme	s, annual physical exa report is good for fiv	am dated within one year, proof we years), titers (if applicable),	
Once admitted into the Nursing or He the Nursing Office. Students in the Al records to the Complio online immun CNA, Acute Care CNA, Central Service	DN, LVN to ADN Step Up, IDC S sization tracking system. The onlin	tep Up, VN or Surgione immunization trac	cal Tech Program must upload	
Student Signature			WC ID#	



Student Signature

SOUTHWESTERN COLLEGE NURSING AND HEALTH OCCUPATIONAL PROGRAMS

HEALTH HISTORY FORM

Health History – TO BE COMPLETED BY THE STUDENT		ES" or "NO"
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:	•	
6. Do you smoke? If yes, packs per day = []	Yes	No
For questions 7-9 below: if you answer "yes," please explain your limitation(s) on	a separate s	heet of paper.
7. Do you have any limitation(s) 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
8. Do you have any limitation(s) in the use of your senses, such as sight or hearing, which would limit your ability to practice a health profession?	Yes	No
9. Do you have any condition which might interfere with your ability to practice a health profession safely? If yes, please explain your limitation(s) in detail on a separate sheet of paper.	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		

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Date

SWC ID#



SOUTHWESTERN COLLEGE NURSING AND HEALTH OCCUPATIONAL 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.

(PRINT CLEARLY)	La	ıst		Fir	st	Middle
BP	P	R	Ht		Wt	
Vision:		Normal	Abnormal	R.Eye 20 Glasses	/ L.Eye 20/	C/Lens ☐ Yes ☐ No
Hearing:						
If Abnormal , please decibel information.	complete the	following		500 hz 1000hz 2000hz	R. Eardcb	L. Ear dcb dcb
				2000NZ	dcb	dcb
PHYSICAL EXAM:	Normal	Abnormal	Description:			
 General Appearance Skin Nodes Skull Ears Eyes Nose Oropharynx Dental Neck & Thyroid Chest Cardiovascular Abdomen Hernia Check Musculoskeletal Neck Back Shoulders Knee Ankle Feet Other Neurological 						
Comments:						



UTHWESTERN COLLEGE NURSING AND HEALTH OCCUPATIONAL 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.
- 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 Occupational Programs. The following health problem(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 the 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.

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IMMUNIZATION REQUIREMENTS

This form must be completed, signed, and stamped by a **Physician, Physician Assistant, Nurse Practitioner, Registered Nurse, Vocational Nurse, Pharmacist or Southwestern College Health Services Nurse (main CV campus).** A copy of immunization records, and/or titers (lab results) <u>must</u> be included with this form for any vaccine or titer given.

IAME:			STUDENT ID#:	
	Last F	First	Middle	
MMR (Me	easles, Mumps, Rubella)	Date #1:	Signature:	HERESTANDE
OR		Date #2:	Signature:	RE HERSTAN
Titers Measles	□Immune □Not Immune	Titer Date:	Signature:	SIPHEND
Mumps	□Immune □Not Immune	Titer Date:	Signature:	STAMP HEAR STAMP S
Rubella	□Immune □Not Immune	Titer Date:	Signature:	MP HERE HERE
lepatitis	B vaccine	Date #1:	Signature:	at app
OR		Date #2:	Signature:	20 CF al
		Date #3:	Signature:	MAP HE STA
Titer	□Immune □Not Immune	Titer Date:	Signature:	SAN HEAD
/aricella/	/IgG vaccine (Chickenpox)	Date #1:	Signature:	HERESTAMPS
OR		Date #2:	Signature:	OX 10 W
Titer	□Immune □Not Immune	Titer Date:	Signature:	MAP HE STA
Pertussis	Diphtheria and Acellular s vaccine (TDAP) vithin 10 years	Date #1:	Signature:	RE JERE A
(current se	/Flu vaccine easonal shot using	Date #1:	Signature:	RE HERE AN
	m form attached-pa 7)			AL HER



SOUTHWESTERN COLLEGE NURSING AND HEALTH OCCUPATIONAL PROGRAMS

TUBERCULOSIS (TB) TEST REQUIREMENTS

		STUDENT ID:	# :
Last	First	Middle	
ogram, unless previously posi	tive. If TB test is positive, a chest	TB skin test) <u>or</u> a QUANTIFERON TB x-ray is required. Chest x-ray results must be cleared by students' healthcare	must be dated with
company this form such as Queasured in mm.	uantiferon TB (blood test), and/or a c	upational Programs, supporting TB decopy of chest x-ray, if applicable. The si from the following: Physician, Ph	ze of indurations m
		rn College Health Services Nurse.	
	STEP #1 - Fir	st PPD Test	
Date:	Manufacturer:	Dose: <u>0.1mL</u>	HERE TAMP STAM
Time Given:	Exp. Date:	_ Lot#:	HERE TAMP HERE TAMP
Date:	Results:mm		IP HEMP HE STE
Time Read:	Read By:		ole IL Ch
	STEP #2 - Second PPD Tes	t (7-21 days after Step #1)	200 230 300
Date:	Manufacturer:	Dose: <u>0.1mL</u>	AFRE AMP HAN
Time Given:	Exp. Date:	_ Lot#:	REFERENCE HERESTANDS
Date:	Results:mm		IP HEROPHE ST
Time Read:	Read By:		STAP HEMP HE
	Ol	R	
	Chest X-Ray (Only if Mantoux p	ositive, Chest X-Ray required)	
Chest X-Ray Date:	☐ Negative ☐ Positive	Signature:	HERE TAMP TAM
(must be dated within five years)	(A copy of the chest X-Ray repo AND proof of positive PPD history	ort must be submitted with this form, ory)	HERE TAMP STAMP
	OF		
	Quantife	eron TB	
Date:	☐ Negative ☐ Positive	Signature:	HERE TAMP STAM
Date	(A copy of the lab report must b	e submitted with this form)	1. 21. 2 B



UTHWESTERN COLLEGE NURSING AND HEALTH OCCUPATIONAL PROGRAMS



San Diego Nursing Service-Education Consortium

2017-2018 Influenza Vaccination Consent

All students/faculty with clinical assignments must comply with the CDC's recommendations for seasonal flu immunization by the deadlines announced by the clinical agencies. The following information is taken from the following website: https://www.cdc.gov/flu/professionals/acip/index.htm.

For the 2017–18 season, quadrivalent and trivalent influenza vaccines will be available. Inactivated influenza vaccines (IIVs) will be available in trivalent (IIV3) and quadrivalent (IIV4) formulations. Recombinant influenza vaccine (RIV) will be available in trivalent (RIV3) and quadrivalent (RIV4) formulations. Live attenuated influenza vaccine (LAIV4) is not recommended for use during the 2017–18 season due to concerns about its effectiveness against (H1N1)pdm09 viruses during the 2013–14 and 2015–16 seasons. Recommendations for different vaccine types and specific populations are discussed. No preferential recommendation is made for one influenza vaccine product over another for persons for whom more than one licensed, recommended product is available. Updates to the recommendations described in this report reflect discussions during public meetings of ACIP held on October 20, 2016; February 22, 2017; and June 21, 2017. New and updated information in this report includes the following:

- Vaccine viruses included in the 2017–18 U.S. trivalent influenza vaccines will be an A/Michigan/45/2015 (H1N1)pdm09–like virus, an A/Hong Kong/4801/2014 (H3N2)-like virus, and a B/Brisbane/60/2008–like virus (Victoria lineage). Quadrivalent influenza vaccines will contain these three viruses and an additional influenza B vaccine virus, a B/Phuket/3073/2013–like virus (Yamagata lineage).
- Information on recent licensures and labelling changes is discussed, including licensure of Afluria Quadrivalent (IIV4; Seqirus, Parkville, Victoria, Australia); Flublok Quadrivalent (RIV4; Protein Sciences, Meriden, Connecticut); and expansion of the age indication for FluLaval Quadrivalent (IIV4; ID Biomedical Corporation of Quebec, Quebec City, Quebec, Canada), previously licensed for ≥3 years, to ≥6 months.
- Pregnant women may receive any licensed, recommended, age-appropriate influenza vaccine.
- Afluria (IIV3; Seqirus, Parkville, Victoria, Australia) may be used for persons aged ≥5 years, consistent with Food and Drug Administration—approved labeling.
- FluMist Quadrivalent (LAIV4; MedImmune, Gaithersburg, Maryland) should not be used during the 2017–18 season due to concerns about its effectiveness against influenza A(H1N1)pdm09 viruses in the United States during the 2013–14 and 2015–16 influenza seasons.

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.

01110 10	the positionity of the time, give reduction	Yes	No
1.	Is this the first 'Flu' vaccination you have ever received?		No
2.	Have you ever had an allergic or serious reaction to the following; Flu vaccine,	ō	
2.	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		
4.	(Aggrenox), or Coumadin (Warfarin) on a daily basis?	ш	
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		
0.	physician.	ш	ш
Dlagga			
	check your appropriate age group:		
Age:	6-18 □ 19-49 □ 50-59 □ 60-64 □ Over 65		
Please	check your appropriate category: □ Student □ Faculty		
	m		
ID#:_	read the CDC 2017-2018 Influenza vaccine information statement. By signing below	100	
		I under	stand and consent to
receive	e the vaccine.		
		1774)	
	Signature: Da	ıte:	
(Print)	**************************************		
Manuf	acturer: Lot #:Exp Date:		
Doute:	IM Site: □ R Deltoid □ L Deltoid FluMist		
	3-03-03-03-03-03-03-03-03-03-03-03-03-03	ate	
ппппет	za Vaccine 2017-2018 Staff Signature D	aic	