Clearance Packet Process

_______1. **Instructors MUST send Student Health Center a copy of their official roster prior to students receiving packets.**

_______2. Student is to follow instructions given by VMC Nurse

______3. Packet is available on student Website.

______ 4. Once all forms are completed (IN BLACK INK ONLY) with immunization records included, need to make an appointment with nurse.

______ 5. If student has no immunization record, VMC nurse will provide vaccine script for all vaccine requirements. Make sure your immunization records are legible and identifiable, pick up updated and complete copy from Imperial County Health Department OR PROVIDER if possible. Will not accept ripped immunization cards/records.

______6. If student has a history of prior positive TB (PPD) student must bring in Chest X-Ray report (valid up to 5 years)

- **If student doesn't have CXR, nurse will provide a script from VMC.**
- **Students will need to fill out a "Signs and Symptoms" form.**

______7. Once VMC Nurse is done reviewing packet she will provide vaccine scripts for needed immunizations, will hand back to student during appt.

______8. Students will only be able to get vaccinations at PCP or local pharmacy with nurse's script.

- **STUDENTS WILL BE RESPONSIBLE FOR ANY FEES.**

_____9. Once student has everything completed, vaccines and physical, nurse will make final copies. One for student and one for instructor and/or unit secretary. Final copies must be stamped "COMPLETED" or "CLEARED" by VMC nurse to be valid.

______10. Submit any of the clearance requirements prior to the designated date. Incomplete or failure to complete all clearance prior to the designated date will result in class and or clinical absence and may cause dismissal from the program as course and program objectives cannot be met without concurrent clinical experience.

****PACKET MUST BE IN ACCEPTABLE CONDITIONS WHEN TURNED IN, IF DAMAGED OR ILLEGIBLE IT WILL NOT BE ACCEPTED****

Student Name_____________________ Signature___________________ Date ___________ Verifier ______

Student Health Center
Phone: (760) 355-6310 – General Information
Phone: (760) 355-6128 (nurse)
Fax: (760) 355-5738

CHILD DEV 100

Semester: _______ Year: _______

HEALTH REQUIREMENTS

Name: ______________________________ **ID: G** ______________________________

Address: ___________________________________ **City:** __________ **Zip:** __________

Date of Birth: ______________ **Age:** _________ **Cell #:** ______________________

Consent: I hereby give my permission to be seen by the SHC Health Professionals. I have read, or had explained to me, the information about the immunization and tuberculosis screening necessary for me to participate in above academic program.

Signature: ____________________________ **Date:** ____________________________

IVC-VMC NURSE USE ONLY! (DO NOT FILL OUT BOTTOM PORTION) IMMUNIZATION REQUIREMENT: ATTACH IMMUNIZATIONS

Required Immunizations/Tests	Date done / Results
☐ **PPD Step-1:** (yearly / current academic year) PPD given by Health Care Agency nursing staff: __________________________ **TB Screening Completed** ☐ yes ☐ no	Date Given: ___/___/___ Date Read: ___/___/___ ☐ Pos. ☐ Neg. Hx Positive PPD ☐ yes ☐ no Hx Positive PPD per student NO records available: ☐ yes ☐ no
QuantiFERON TB-Gold:	Date: ___/ ___/ ___ ☐ Pos. ☐ Neg. ☐ N/A
If positive PPD needs Chest x-ray **If positive** QFT-G/Chest x-ray – refer to ICPHD & PCP **CXR** from: ________________ (1-10 years) **Signs & Symptoms (S&S) review form** ☐ yes ☐ no	Chest x-ray script given (PPD pos.): ___/___/___ ☐ N/A Refer to ICPHD & PCP for f/u medical evaluation & TX: ___/___/___ ☐ N/A ___/___/___ ☐ Neg. ☐ Pos. ☐ N/A ___/___/___ ☐ Neg. ☐ Pos. ☐ N/A
Influenza Vaccine (yearly / current academic year) ☐ Pending (currently not available) ☐ yes ☐ refused	___/___/___ ☐ received – see form ___/___/___ ☐ declined/see form ☐ Refused sign form
MMR (2 Doses) (Every 20 years) **MMR Titer**	1. ___/___/___ 2. ___/___/___ ___/___/___ Result ☐ Pos. ☐ Neg. ☐ N/A Script Given: ___/___/___
Tdap (every 10 years)	Date given ___/___/___
COVID -19 Vaccine (brand name):________________ *Optional - Recommended*	1st Dose ____/____/____ 2nd Dose ___/___/____

IVC - VMC NURSE (ONLY)

___________________, L.V.N. Access File: ____________________

IMPERIAL VALLEY COLLEGE
STUDENT HEALTH SERVICES

Phone: 760-355-6310 Fax: 760-355-5738

TUBERCULOSIS SCREENING

Name_______________________________________ Today's date: ____________________

Date of Birth:__________________ Age:______________ ID: G________________________

Address: ____

City:________________________ Zip:__________________ Cell # ______________________

Please answer and sign:

Have you ever had a Skin Test done for tuberculosis? ☐ NO ☐ Yes

What was the result? ☐ Negative (step 1) ☐ Positive (step 2)

Signature: ____

OFFICE USE ONLY

☐ **Student has history of positive ppd on __/ __/ __**

1*-Step - TST (tuberculin skin test).** ***If negative see resolution below.

TST given on:_________by:__________Results:__________mm. ☐Neg. ☐Pos. is ≥10mm

Read by:____________________________L.V.N Date read: __________________________________

***2*-Step - TST, after 1 week**

TST given on:_________by:__________Results:__________mm. ☐Neg. ☐Pos. is ≥10mm

Read by:____________________________L.V.N Date read: __________________________________

***3*-Step – Q-Gold (QuantiFeron)**

Q-Gold given on:_____________by:______________Results:_________mm. ☐Neg. ☐Pos. is ≥10mm

---

Positive TB? ☐ Yes ☐ No Last CXR Date:__________________ Facility:__________________

CXR Script Given? ☐ Yes ☐ No Date Given:_____________________ ☐ Neg. ☐ Pos.

CXR Completed at:

☐ PMHD ☐ ECRMC ☐ Other:________________________________ Date: ____________________

RESOLUTION: ☐ CLEARED

BY:____________________L.V.N TODAY'S DATE: __________________

Imperial Valley College - *Student Health Center*

HISTORY FORM

The information you provide in this statement will be used to assess your medical qualifications to participate in the Imperial Valley College approved programs. Please complete the history form carefully and thoroughly. All information will be kept confidential.

NAME:__________________________________ **DOB:**__________________ **G#:**___________________

MEDICAL HISTORY:

Please answer the following. Circle YES or NO or N/A (NOT APPICABLE) on each question – EXPLAIN – TYPE (where applicable)

Do you have or have you ever had any of the following?

Yes	No	Diabetes Mellitus	Yes	No	Musculoskeletal/Arthritis/Injury
Yes	No	High Blood Pressure	Yes	No	Neurological problems
Yes	No	Asthma/Allergies	Yes	No	Psychiatric Disease
Yes	No	High Cholesterol			Type: ____________________________
Yes	No	Heart Disease - Type:___________________ Special Testing: _____________________	Yes	No	Other List:______________________________

Current Medications or Supplements: ☐ **NONE** ☐ **YES, LIST MEDICATIONS (below)**

Other medication(s):

1.__________________________ **3.** __________________________ ______________________

2.__________________________ **4.** __________________________ ______________________

Allergies: ☐**NONE** ☐**YES, LIST ALLERGIES (below)**

Yes	**NO**	**Will you be able to lift 35 pounds?**	**Reason if No?**
Yes	**NO**	**Are you Medically or Physically Disabled?**	**Reason if Yes?**

SURGICAL HISTORY:

☐ **NO** ☐ **Yes (if yes explain below)**

____ Date: ___________________

____ Date: ___________________

____ Date: ___________________

SOCIAL HISTORY:

Tobacco: ☐Current ☐Past ☐N/A How Much?________________________
Alcohol: ☐Current ☐Past ☐N/A How Much?________________________
Drugs: ☐Current ☐Past ☐N/A How Much?________________________

EXERCISE – Type ?: _____________________
____
How often ?: ______________________________

FAMILY HISTORY: **Circle Yes or No – Which 'Family Member'?**

Yes	No	Diabetes Mellitus – Type:	Yes	No	High Cholesterol
Yes	No	High Blood Pressure	Yes	No	Heart Disease – Type: **(write below)**
Yes	No	Stroke	Yes	No	Psychiatric Disease – Type: **(write below)**

Additional comments/Information:

____

____

____

I hereby certify that all statements made in this 'History' form are accurate and complete.

________________________ ___________________________________ ________________

Print Name **Signature** **Date**

Declination of Influenza Vaccination

Student's Name: ____________________

Student's G#: ____________________

Under California Code of Regulations Title 8 5199(h) (10), I understand I have the right to decline.

I have been advised that I should receive the influenza vaccine to protect myself and the children I serve. I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a healthcare provider. I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands in the United States each year.
- Influenza vaccination is recommended for me and all other child care staff to protect this program's children from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to the children in this program.
- If I become infected with influenza, I can spread sever illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including the children in this program, coworkers, my family and my community.

I acknowledge that I have read this document in its entirety and fully understand it. Despite these facts, I have decided to decline the influenza vaccine by my signature below. I realize that I may re-address this issue at any time and accept vaccination in the future.

Signature: ____________________

Date: ____________________