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. Public Health Department now open only by appointment.**

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

_____**9. Once immunizations are in progress, SHC reception will schedule student's physical exam if required for appropriate program.**

- **Please contact the Student Health Center for available physical times.**

_____**10. 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.**

_____**11. 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** _____

Vaccinations/Immunizations

The required immunizations while in the nursing program are: Influenza (flu), MMR (Measles, Mumps, Rubella), Tdap (Diphtheria, Tetanus, Pertussis), Hepatitis B (3 series), and Varicella. It is the student's responsibility to maintain their immunization paperwork either hard-copy or through the COMPLIO online program. The IVC Student Health Center can assist with these requirements.

- Influenza - Required during flu season (October and March). The vaccination expires after March and required the next flu season
- MMR – two (2) step injection required
- Tdap – One dose required
- Hepatitis B – All 3 shots required
  - Hepatitis B shots will incur a cost. It is a series of 3 doses taken within a specific timeframe as directed by the healthcare practitioner. Students may start the program if series not completed, but student must complete the series as soon as possible according to vaccination schedule.
- Varicella (Chickenpox) – 2 doses required, or had disease
  - The Varicella vaccine will incur a cost. Students who have had the disease will need to verify **in writing and only** by a healthcare practitioner, the month and year of occurrence. If no record is available, the vaccine will be required.

Refusal of Immunizations, Vaccinations, Titers and/or TB requirements

1. Waiver/Refusal Form for the Influenza or other vaccinations must be completed noting rationale for refusal. Refusal must be approved by the Department.
2. If refusing, the student understands the nursing program will make a reasonable effort to secure alternative clinical experiences, but these experiences **may not** be available. If **alternative sites are unavailable, it may result in dismissal** from the program as the student will be unable to complete clinical requirements.

Tuberculin Skin Test (TB),

- A Mantoux Tuberculin (TB) Skin Test (TST) is required every 12 months.
  - A two (2) step test is required OR
  - QuantiFERON ®- TB Gold Test)
  - More information regarding the PPD is available at http://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm
- It is the student's responsibility to make sure they have updated testing and submitted documentation prior to the 12 months.
- If the student's TB skin test is positive, a chest x-ray will be required.

☐ *I acknowledge that I have read and understand the immunization guidelines.*

Name: _____ *Signature* _____ *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? _____ **EXERCISE** – Type ?: _____

Alcohol: ☐Current ☐Past ☐N/A How Much? _____ _____

Drugs: ☐Current ☐Past ☐N/A How Much? _____ 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**

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

HEALTH STATUS UPDATE FORM FOR POSITIVE TB TESTING

IF YOU HAVE A POSITIVE TB Testing (Tuberculin Skin Test (TST) or QuantiFeron-TB Gold (QFT-G), YOU MUST COMPLETE THIS FORM AND RETURN TO THE STUDENT HEALTH CENTER.

A positive skin test generally means that sometime during your life you have come in contact with the tuberculosis bacteria. Your body has made antibodies against tuberculosis bacteria and that is why your test turned "positive." It does not mean that you have tuberculosis.

Your initials confirm that you understood the following statements:

_____ The QuantiFeron-TB Gold test (QFT-G) is a whole-blood test use in diagnosing Mycobacterium tuberculosis infection. A positive QFT indicates M tuberculosis is in your blood. A chest x-ray may be needed to confirm the diagnosis.

_____ Confidential Morbidity Report will be submitted to Imperial County Health Department and they may contact you for possible prophylactic treatment and or follow-up.

_____ You will be responsible in informing your Primary Care Physician of the result and potential prophylactic treatment regimen.

_____ SHC will inform the IVC Program Coordinator of the above findings.

Print Name: _____ Date of Birth: _____ G#: _____	Program:	□ LVN	□ Preschool
	□ Paramedic	□ CNA	□ Child Dev.
	□ Firefighter	□ MA	□ EDUC 200
	□ EMT	□ HHA	□
	□ RN	□ WKStudy	□

DO YOU HAVE ANY?	YES	NO
Productive cough which has lasted at least three (3) weeks?		
Persistent weight loss without dieting?		
If yes, how many pounds did you lose? Since when?		
Persistent low grade fever?		
Night sweats?		
Loss of appetite?		
Swollen glands, usually in the neck?		
Coughing up blood?		
Shortness of breath?		
Chest pain?		

Date and reason you last consulted your personal physician:

What treatment/medication was given or prescribed?

Describe any illnesses you have had in the past year:

To the best of my knowledge, I am free from illness and capable of performing my duties.

Print Name: Student Signature:	Date:
Reviewed by SHC Nurse: L.V.N.	Date:

Imperial Valley College Program: _____

Student Health Center (760) 355-6310 / Fax (760) 355-5738

PHYSICAL FORM

Name: _____ **ID: G** _____ **SS#:** _____

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 NURSE USE ONLY!!

IMMUNIZATION REQUIREMENT: ATTACH IZ RECORD & TEST RESULTS

Required Immunization/Test	Date done/Results	Required Immunization	
☐ 1. Q- Gold ☐ 2. X-Ray ☐ 3. Health History Update	1. ☐Neg ☐Pos 2. ☐Neg ☐Pos (Q-2years) 3. _____ _____ _____	Varicella (chicken pox) 1. ___/___/___ 2. ___/___/___ Titer☐ _____/___/___ ☐Neg. ☐Pos.	☐ Had disease ☐ Yes, script given ☐ No, script not given
☐ Tdap (Every 10 years)	1. ___/___/___	Hepatitis B (3 doses) 1. ___/___/___ 2. ___/___/___ 3. ___/___/___ Titer _____/___/___ ☐Neg. ☐Pos.	☐Yes, script given ☐No, script not given
☐ MMR (2 doses) ☐ Titer	1. ___/___/___ 2. ___/___/___ 1. ___/___/___☐Neg ☐Pos		
Flu (attach consent/decline form)	1. ___/___/___		
COVID- 19 Vaccine	Brand name: _____	1st Dose: ___/___/___ 2nd Dose:___/___/___ 3rd Dose (Booster): ___/___/___	

IVC SHC NURSE PRACTITIONER / PRIMARY PHYSICIAN USE ONLY!!

EXAMINATION:

Height:_____inches Weight: _____lbs. BMI:

Blood Pressure: _____ Pulse: _____ Repeat BP: _____ Pulse:

Vision: R: _____L: _____ ☐ with ☐ without glasses / contact lenses

Area	Normal	Abnormal Findings
Vital signs		
Skin		

Lymphatic		
Head		
Ears		
Eyes		
Nose		
Mouth /throat		
Neck		
Back and spine		
Shoulders		
Upper extremities		
Heart		
Lungs		
Abdomen		
Gastrointestinal		
Lower extremities		
Other		

Comments and General Health Recommendations:

☐ ABLE TO LIFT 35 LBS.

_____Cleared

I certify that as the health examiner, I have completed the appraisal on the above student, and affirm that this person is free of disease to perform assigned program duties and do not have any health condition that would create a hazard for himself/herself, fellow classmates, patients or visitors.

_____	_____	
Provider	Date	Provider Stamp

Cleared with the following recommendations

I have been informed of the above recommendations and given education materials on:

☐ Hypertension ☐ Diabetes Mellitus ☐ Diet ☐ Exercise ☐ Vision problems

I also received copy of my History, Physical, and TB Screening forms.

Student (Print Name): _____

Signature: _____Date: _____

_____LVN _____Date