**STUDENT HOUSING PACKET**

**Student Name:** ________________________________________ **G#:** ___________________________

**Contact Number:** _________________________________

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# OFFICE USE ONLY

**Pkg Drop Off at SHC:** Date:______________________________ Reviewed by: _____________________

**Called Student for Pkg Pickup:**

Date:__________________________ ☐ Confirmed Pickup ☐ No Answer / Left Voicemail ☐ Other

Date:__________________________ ☐ Confirmed Pickup ☐ No Answer / Left Voicemail ☐ Other

Date:__________________________ ☐ Confirmed Pickup ☐ No Answer / Left Voicemail ☐ Other

**Physical Appointment:** ☐ Required ☐ Not Required Date: _______________ Time:________________

**Notes:**

________________________________________________________________________________

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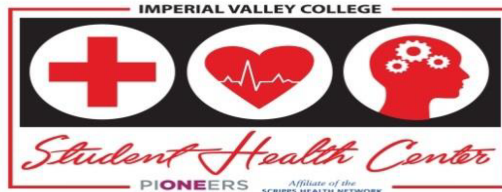


Clearance Packet Process

_______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 SHC 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, SHC 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 PMHD.**
- **Students will need to fill out a "Signs and Symptoms" form.**

**______7. Once SHC 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 immunizations are in progress, SHC reception will schedule student's physical exam if required for appropriate program.**

- **Physicals take place ONLY on Wednesdays from 9:00am – 11:00am**

**_____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 SHC 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 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. 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.

**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 (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:**

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## IVC NURSE USE ONLY!!

## IMMUNIZATION REQUIREMENT: ATTACH IZ RECORD & TEST RESULTS

| Required Immunization/Test | Date done/Results | Required Immunization | |
|---|---|---|---|
| ☐ PPD step 1 (Yearly)<br><br>☐ PPD step 2 | 1. Date Given: ___/___/___<br>Date Read: ___/___/___<br>☐ Neg. ☐ Pos.<br>2. Date Given: ___/___/___<br>Date Read: ___/___/___<br>☐ Neg. ☐ Pos. | Varicella (chicken pox)<br>1. ___/___/___<br>2. ___/___/___<br>Titer ___/___/___<br>☐ Neg. ☐ Pos. | ☐ Had disease<br>☐ Yes, script given<br>☐ No, script not given |
| If positive, Q-Gold<br>Chest x-ray | 1. ___/___/___ ☐ Neg. ☐ Pos.<br>1. ___/___/___ ☐ Neg. ☐ Pos. | Hepatitis B (3 doses)<br>1. ___/___/___<br>2. ___/___/___<br>3. ___/___/___<br>Titer ___/___/___<br>☐ Neg. ☐ Pos. | ☐ Yes, script given<br>☐ No, script not given |
| ☐ Tdap (Every 10 years) | 1. ___/___/___ | | |
| MMR (2 doses)<br><br>Titer | 1. ___/___/___<br>2. ___/___/___<br><br>1. ___/___/___ ☐ Neg. ☐ Pos. | | |
| Flu (attach consent/decline form) | 1. ___/___/___ | Note: | |
| COVID-19 Vaccine (brand name): ________________<br>*Optional - Recommended* | 1st Dose ___/___/___ | 2nd Dose___/___/___ | |

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## 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 ________________________

Cleared with the following recommendations

☐ ABLE TO LIFT 35 LBS.

***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 ________________________ Access File

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**

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

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

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

**CXR Completed at:**

☐ PMHD ☐ ECRMC ☐ Other:__________________________________ Date: _____________________

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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: ___________________________________<br>Date of Birth: _________________ G#: _____________ | Program:<br>☐ Paramedic<br>☐ Firefighter<br>☐ EMT<br>☐ RN | ☐ LVN<br>☐ CNA<br>☐ MA<br>☐ HHA<br>☐ WKStudy | ☐ Preschool<br>☐ Child Dev.<br>☐ EDUC 200<br>☐ Student Housing<br>☐ |
|---|---|---|---|

| 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:<br>Student Signature: | Date: |
|---|---|
| Reviewed by SHC Nurse: L.V.N. | Date: |

Revised: 08/21/2019