



**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 (primary): \_\_\_\_\_  
*\* **all program communications will be via SWC e-mail***  
Secondary 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 most current documentation to SWC Nursing & Health Occupation Programs Office.

**Once admitted into the Nursing or Health Occupation Program, I will be required to upload all records to my Complio account. This online immunization tracking system applies to ALL programs. Complio must remain compliant at all times.**

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
SWC ID#



HEALTH HISTORY FORM

Health History – <b>TO BE COMPLETED BY THE STUDENT</b>	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:		
6. Do you smoke? If yes, packs per day = [    ]	Yes	No
<b>For questions 7-9 below: if you answer “yes,” please explain your limitation(s) on a separate sheet of paper.</b>		
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
<b>PLEASE INDICATE WITH A CHECK IF YOU OR A FAMILY MEMBER HAVE HAD:</b>	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#



TO BE COMPLETED BY PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER: 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 CLEARLY) Last First Middle

BP \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ Ht. \_\_\_\_\_ Wt. \_\_\_\_\_

Normal Abnormal Vision: \_\_\_\_\_ R.Eye 20/ L.Eye 20/  
Glasses  Yes  No C/Lens  Yes  No

Hearing: \_\_\_\_\_ R. Ear L. Ear  
If Abnormal, please complete the following decibel information. 500 hz \_\_\_\_\_ dcb \_\_\_\_\_ dcb  
1000hz \_\_\_\_\_ dcb \_\_\_\_\_ dcb  
2000hz \_\_\_\_\_ dcb \_\_\_\_\_ dcb

PHYSICAL EXAM:

Table with 4 columns: Normal, Abnormal, Description, and a blank column for notes. Rows include: 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), and Neurological.

Comments: \_\_\_\_\_



# NURSING AND HEALTH OCCUPATIONAL PROGRAMS

## Supplemental Medical Guidelines

### TO BE COMPLETED BY PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER:

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. The 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 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.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_ SWC ID#: \_\_\_\_\_



IMMUNIZATION REQUIREMENTS

This form must be completed and signed 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) 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: \_\_\_\_\_
Date #2: \_\_\_\_\_ Signature: \_\_\_\_\_

OR

MMR Titers (Blood Test)
Measles [ ] Immune [ ] Not Immune Titer Date: \_\_\_\_\_ Signature: \_\_\_\_\_
Mumps [ ] Immune [ ] Not Immune Titer Date: \_\_\_\_\_ Signature: \_\_\_\_\_
Rubella [ ] Immune [ ] Not Immune Titer Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Hepatitis B vaccine
Date #1: \_\_\_\_\_ Signature: \_\_\_\_\_
Date #2: \_\_\_\_\_ Signature: \_\_\_\_\_
Date #3: \_\_\_\_\_ Signature: \_\_\_\_\_

OR

Hepatitis B Titer (Blood Test)
[ ] Immune [ ] Not Immune Titer Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Varicella vaccine (Chickenpox)
Date #1: \_\_\_\_\_ Signature: \_\_\_\_\_
Date #2: \_\_\_\_\_ Signature: \_\_\_\_\_

OR

Varicella Titer (Blood Test)
[ ] Immune [ ] Not Immune Titer Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Tetanus/Diphtheria and Acellular Pertussis vaccine (TDAP)
Must be within 10 years Date #1: \_\_\_\_\_ Signature: \_\_\_\_\_

Influenza/Flu vaccine (Current seasonal flu shot)
Date #1: \_\_\_\_\_ Signature: \_\_\_\_\_

Flu shot must be obtained and documentation provided. The new flu shot season begins August/September each year. The 2020-2021 Influenza Vaccination Consent form on page 7 must be completed at the time you receive the flu shot.



### TUBERCULOSIS (TB) TEST REQUIREMENTS

NAME: \_\_\_\_\_ STUDENT ID#: \_\_\_\_\_  
Last First Middle

All Health Profession students are required to have a 2-Step PPD (two negative TB skin tests) or a blood test for TB infection (per CDC, these include IGRA's; QuantiFERON; SPOT TB test or T-Spot; or GAMMA INTERFERON) prior to starting program, *unless previously positive*.

**If TB test is positive, documentation must be provided and a chest x-ray is required. Chest x-ray results must be dated within five years**

This form must be completed and signed by a **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: <u>0.1mL</u> 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: <u>0.1mL</u> Exp. Date: _____ Lot#: _____ Given By: _____
Date: _____ Time Read: _____	Results: _____ mm Read By: _____

OR

BLOOD TEST for TB Infection (per CDC: IGRA's; QuantiFERON; SPOT TB test or T-Spot; or GAMMA INTERFERON)	
Date: _____	<input type="checkbox"/> Negative <input type="checkbox"/> Positive    Signature: _____ <b>(A copy of the lab report must be submitted with this form)</b>

**(ONLY if positive TB test result, Chest X-Ray required. Proof of positive TB is required for Chest X-Ray to be valid)**

Chest X-Ray	
Chest X-Ray Date: _____ <i>(must be dated within five years)</i>	<input type="checkbox"/> Negative <input type="checkbox"/> Positive    Signature: _____ <b>(A copy of the chest X-Ray report must be submitted with this form <u>AND</u> proof of positive PPD history)</b>



San Diego Nursing and Allied Health Service-Education Consortium

2020-2021 Influenza Vaccination Consent

All students/faculty with clinical assignments must comply with the CDC's recommendations for seasonal flu immunization by November 1, 2020 or as otherwise announced by a clinical agency.

There are many different flu viruses and they are constantly changing. Detailed information about the 2020-2021 flu season and vaccines available can be accessed through the CDC's website:

https://www.cdc.gov/flu/season/faq-flu-season-2020-2021.htm.

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.

- 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) or others 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 and category:

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

Category: [ ] Student [ ] Faculty

ID #: \_\_\_\_\_ Telephone: \_\_\_\_\_

I have read the CDC 2020-2021 Influenza vaccine information statement. By signing below, I understand and consent to receive the vaccine.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Manufacturer: \_\_\_\_\_ Lot #: \_\_\_\_\_ Exp Date: \_\_\_\_\_

Route: IM Site: [ ] R Deltoid [ ] L Deltoid FluMist \_\_\_\_\_

Influenza Vaccine 2020-2021 Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

STAMP of PROVIDER: