



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 (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 hereby consent to the communication of my health records 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 of my physical exam, proof of vaccines and/or titers, TB test results, flu shot and other required health/medical records 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 DISA/Complo account. This online immunization tracking system applies to ALL programs. DISA/Complo must remain compliant at all times.

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

\_\_\_\_\_  
Date

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

**Physical exams are good for one year.**



SOUTHWESTERN COLLEGE

**NURSING AND HEALTH OCCUPATIONAL PROGRAMS****HEALTH HISTORY FORM**

| <b>Health History – TO BE COMPLETED BY THE STUDENT</b>                                                                                                                                         | <b>CHECK “YES” or “NO”</b> |                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------|
| 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>                                                                                                                        | <b>SELF</b>                | <b>FAMILY MEMBER</b> |
| 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#



## NURSING AND HEALTH OCCUPATIONAL PROGRAMS

**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.

**Physical exams are good for one year.**

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: \_\_\_\_\_

If **Abnormal**, please complete the following decibel information.

|        |           |           |
|--------|-----------|-----------|
|        | R. Ear    | L. Ear    |
| 500 hz | _____ dcb | _____ dcb |
| 1000hz | _____ dcb | _____ dcb |
| 2000hz | _____ dcb | _____ dcb |

### PHYSICAL EXAM:

|                       | Normal | Abnormal | Description: |
|-----------------------|--------|----------|--------------|
| 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              | _____  | _____    | _____        |
| 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 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 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#: \_\_\_\_\_



SOUTHWESTERN COLLEGE

## NURSING AND HEALTH OCCUPATIONAL PROGRAMS

## 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

|                                              |                |                  |
|----------------------------------------------|----------------|------------------|
| <b>MMR (Measles, Mumps, Rubella) vaccine</b> | Date #1: _____ | Signature: _____ |
|                                              | Date #2: _____ | Signature: _____ |

**OR**

|                                                                             |                   |                  |
|-----------------------------------------------------------------------------|-------------------|------------------|
| <b>MMR Titers (Blood Test)</b>                                              |                   |                  |
| Measles <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune | Titer Date: _____ | Signature: _____ |
| Mumps <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune   | Titer Date: _____ | Signature: _____ |
| Rubella <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune | Titer Date: _____ | Signature: _____ |

|                            |                |                  |
|----------------------------|----------------|------------------|
| <b>Hepatitis B vaccine</b> | Date #1: _____ | Signature: _____ |
|                            | Date #2: _____ | Signature: _____ |
|                            | Date #3: _____ | Signature: _____ |

**OR**

|                                                                                                              |                   |                  |
|--------------------------------------------------------------------------------------------------------------|-------------------|------------------|
| <b>Hepatitis B Titer (Blood Test)</b><br><input type="checkbox"/> Immune <input type="checkbox"/> Not Immune | Titer Date: _____ | Signature: _____ |
|--------------------------------------------------------------------------------------------------------------|-------------------|------------------|

|                                       |                |                  |
|---------------------------------------|----------------|------------------|
| <b>Varicella vaccine (Chickenpox)</b> | Date #1: _____ | Signature: _____ |
|                                       | Date #2: _____ | Signature: _____ |

**OR**

|                                                                                                            |                   |                  |
|------------------------------------------------------------------------------------------------------------|-------------------|------------------|
| <b>Varicella Titer (Blood Test)</b><br><input type="checkbox"/> Immune <input type="checkbox"/> Not Immune | Titer Date: _____ | Signature: _____ |
|------------------------------------------------------------------------------------------------------------|-------------------|------------------|

|                                                                                                    |                |                  |
|----------------------------------------------------------------------------------------------------|----------------|------------------|
| <b>Tetanus/Diphtheria and Acellular Pertussis vaccine (TDAP)</b><br><i>Must be within 10 years</i> | Date #1: _____ | Signature: _____ |
|----------------------------------------------------------------------------------------------------|----------------|------------------|

|                                                                                                  |                  |                  |
|--------------------------------------------------------------------------------------------------|------------------|------------------|
| <b>Covid 19 vaccine</b> (Only Moderna, Pfizer and Johnson & Johnson's Janssen vaccines accepted) | Date #1: _____   | Signature: _____ |
|                                                                                                  | Date #2: _____   | Signature: _____ |
|                                                                                                  | Booster 1: _____ | Signature: _____ |



SOUTHWESTERN COLLEGE

## NURSING AND HEALTH OCCUPATIONAL PROGRAMS

## ANNUAL 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: _____<br>Time Given: _____                    | Manufacturer: _____ Dose: <u>0.1mL</u><br>Exp. Date: _____ Lot#: _____<br>Given By: _____ |
| Date: _____<br>Time Read: _____                     | Results: _____ mm<br>Read By: _____                                                       |
| STEP #2 - Second PPD Test (7-21 days after Step #1) |                                                                                           |
| Date: _____<br>Time Given: _____                    | Manufacturer: _____ Dose: <u>0.1mL</u><br>Exp. Date: _____ Lot#: _____<br>Given By: _____ |
| Date: _____<br>Time Read: _____                     | Results: _____ mm<br>Read By: _____                                                       |

OR

| BLOOD TEST for TB Infection<br>(per CDC: IGRA's; QuantiFERON; SPOT TB test or T-Spot; or GAMMA INTERFERON) |                                                                                                                                                            |
|------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Date: _____                                                                                                | <input type="checkbox"/> Negative <input type="checkbox"/> Positive Signature: _____<br><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: _____<br>(must be dated within five years) | <input type="checkbox"/> Negative <input type="checkbox"/> Positive Signature: _____<br><b>(A copy of the chest X-Ray report must be submitted with this form <u>AND</u> proof of positive PPD history)</b> |



SOUTHWESTERN COLLEGE

## NURSING AND HEALTH OCCUPATIONAL PROGRAMS



*San Diego Nursing and Allied Health  
Service-Education Consortium*

**Annual Influenza Vaccination Consent**

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

There are many different flu viruses, and they are constantly changing. Detailed information about the flu season and vaccines available can be accessed through the CDC's website: <https://www.cdc.gov/flu/index.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.*

- |                                                                                                                                                                                   | Yes                      | No                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Is this the first "Flu" vaccination you have ever received?                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 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)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you ill today?                                                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you take blood thinners such as Aspirin, Clopidogrel (Plavix), Dipyridamole (Aggrenox), or Coumadin (Warfarin) or others on a daily basis?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you under 18 years of age? <i>If yes, parental consent is required.</i>                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you pregnant? If yes, you must provide written permission from your physician.                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |

*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 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 Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

**STAMP of PROVIDER:**