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 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#

SOUTHWESTERN COLLEGE **NURSING AND HEALTH OCCUPATIONAL PROGRAMS**

HEALTH HISTORY FORM

Health History – TO BE COMPLETED BY THE STUDENT	**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
For questions 7-9 below: if you answer "yes," please explain your limitation(s) on a separate sheet of paper.		
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
PLEASE INDICATE WITH A CHECK IF YOU OR A FAMILY MEMBER HAVE HAD:	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#

NURSING AND HEALTH OCCUPATIONAL PROGRAMS

TO BE COMPLETED BY PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTIONER: 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:	_____	_____		

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 PRACTIONER:

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#: _____

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

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 2019-2020 Influenza Vaccination Consent form on page 7 must be completed at the time you receive the flu shot.

SOUTHWESTERN COLLEGE **NURSING AND HEALTH OCCUPATIONAL PROGRAMS**

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; QuanitFERON; 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: 0.1mL 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: 0.1mL Exp. Date: _____ Lot#: _____ Given By:
Date: _____ Time Read: _____	Results: _____mm Read By: _____

OR

BLOOD TEST for TB Infection (per CDC: IGRA's; QuanitFERON; SPOT TB test or T-Spot; or GAMMA INTERFERON)	
Date: _____	☐ Negative ☐ Positive Signature: _____ **(A copy of the lab report must be submitted with this form)**

(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: _____ (must be dated within five years)	☐ Negative ☐ Positive Signature:_____ **(A copy of the chest X-Ray report must be submitted with this form AND proof of positive PPD history)**

San Diego Nursing Service-Education Consortium

2019-2020 Influenza Vaccination Consent

All students/faculty with clinical assignments must comply with the CDC's recommendations for seasonal flu immunization by the deadlines announced by the clinical agencies. The following information is taken from the CDC's website. Please refer to the CDC link if you want more information.
https://www.cdc.gov/flu/season/flu-season-2019-2020.htm

There are many different flu viruses and they are constantly changing. For 2019-2020, trivalent (three-component) vaccines are recommended to contain:

- A/Brisbane/02/2018 (H1N1)pdm09-like virus (updated)
- A/Kansas/14/2017 (H3N2)-like virus (updated)
- B/Colorado/06/2017-like (Victoria lineage) virus

Quadrivalent (four-component) vaccines, which protect against a second lineage of B viruses, are recommended to contain:

- the three recommended viruses above, plus B/Phuket/3073/2013-like (Yamagata lineage) virus.

The World Health Organization (WHO) made the selection of the H1N1 and both B components for 2019-2020 Northern Hemisphere flu vaccines on February 21 and at that time decided to delay the decision on an H3N2 vaccine component. FDA's Vaccines and Related Biological Products Advisory Committee (VRBPAC) also selected the H1N1 and B components at their first meeting on March 6, but also decided to postpone the selection of the H3N2 component. WHO selected the H3N2 component listed above on March 21, 2019. VRBPAC chose the same H3N2 component for U.S. vaccines on March 22, 2019.

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?	☐	☐
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 2019-2020 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 2019-2020 Staff Signature _____ Date _____

STAMP of PROVIDER: