ARE YOUR NURSING ASSISTANT HEALTH SCREENING REQUIREMENTS COMPLETE?

STUDENT NAME: ___________________________ DATE: ________________

ANSWER THIS CHECKLIST AND PLACE ON TOP OF YOUR RECORDS. THE RECORDS MUST BE SUBMITTED TO THE “LOCK-BOX” LOCKBOX IN GILLMOR CENTER 235

Important: This checklist must be completed and returned with required documents by Wednesday, January 15th, 2020. Please do not staple or fold forms.

Yes ☐ No ☐ I AM SUBMITTING A COMPLETED PHYSICAL EXAM PERFORMED BY A PHYSICIAN OR NURSE PRACTITIONER.

Yes ☐ No ☐ I AM SUBMITTING A COPY OF MY CURRENT IMMUNIZATION RECORD.

Yes ☐ No ☐ I AM SUBMITTING A COPY OF “TB SYMPTOMS REVIEW” FORM SIGNED BY A LICENSED MEDICAL PROVIDER.

Yes ☐ No ☐ I HAVE HAD TWO (2) TB SKIN TESTS DONE (1-3 WEEKS APART) OR A QUANTIFERON BLOOD TEST IN THE PAST 12 MONTHS. IF MY SKIN TESTS HAVE EVER BEEN “POSITIVE,” I AM INCLUDING THE RESULTS (IN MM) AND A RECENT (WITHIN THE LAST FIVE YEARS) CHEST XRAY REPORT.

Yes ☐ No ☐ I HAVE HAD MEASLES, MUMPS, AND RUBELLA ANTIBODY TITERS AND I AM INCLUDING THE RESULTS.

Yes ☐ No ☐ I HAVE HAD A VARICELLA ANTIBODY TITER AND I AM INCLUDING THE RESULT.

Yes ☐ No ☐ I HAVE HAD HEPATITIS B SURFACE ANTIBODY TITER AND I AM INCLUDING THE RESULT.

Yes ☐ No ☐ I HAVE HAD (TDAP) TETANUS/DIPHTHERIA/ACELULAR PERTUSSIS VACCINE WITHIN PAST TEN (10) YEARS AND AM INCLUDING DOCUMENTATION.

Yes ☐ No ☐ I HAVE HAD FLU VACCINE FOR THE CURRENT SEASON AND AM INCLUDING DOCUMENTATION.

Yes ☐ No ☐ I HAVE INCLUDED A COPY OF ALL LAB RESULTS

Yes ☐ No ☐ I understand All materials submitted for purposes of admission into the program become the property of the Health Occupations Department and will not be returned. For this reason, I have made a copy of all my forms before submission.

NOTE: “TITER(S)” REFERS TO A BLOOD TEST THAT CONFIRMS IMMUNITY. IF ANY OF YOUR TITERS ARE “NON-IMMUNE,” YOU MUST RECEIVE THE ASSOCIATED VACCINE.

BRING ALL OF YOUR IMMUNIZATION RECORDS TO YOUR PERSONAL HEALTHCARE PROVIDER.

SOME TESTS REQUIRE 10-14 DAYS TO COMPLETE.

IF YOU DO NOT HAVE HEALTH INSURANCE OR HAVE HIGH INSURANCE CO-PAYs, YOU MAY MAKE AN APPOINTMENT AT THE MISSION COLLEGE STUDENT HEALTH SERVICES, 408-855-5140.
HEALTH OCCUPATIONS PROGRAMS

Dear Doctor or Nurse Practitioner:

Applicants admitted to any Health Occupations Program at Mission College must have a complete physical examination within 3 months prior to the beginning of the program. We are dependent upon your evaluation of the applicant’s health status in determining his or her eligibility for admission. Where physical or emotional health limitations exist, we appreciate your considered opinion as to the relevance of these limitations in the practice of nursing.

Titer levels are required for all students entering Health Occupations Programs. Immunizations are not proof of immunity and will not be accepted. Mission College policies are designed to comply with clinical agency requirements and the recommendations of the State of California Department of Health Services.

Please include with the physical examination, a copy of the following:

- PPD – 2 step Tuberculin skin test (2 complete PPD tests. 1st PPD followed by 2nd PPD in 2 to 3 weeks). QuantiFERON® - TB Test accepted. If TB test is positive, a Chest X-ray is required.
- Chest x-rays will not be accepted unless previous positive PPD or QuantiFERON® results attached. Chest X-ray must be within 5 years of starting the program.
- Tdap – (10 year booster). Tdap is required for Pertussis booster
- Titer levels for Rubella, Rubeola, Mumps, Varicella, and Hepatitis B Surface Antibody. Immunizations required if titer levels do not verify immunity.
- Include current Flu vaccine
- Student will need a copy of their lab results.

Thank you for your assistance.

Cynthia Anderson, RN, DSD
Director, Nursing Assistant Program
phone: (408) 855-5303
e-mail: cynthia.anderson@missioncollege.edu

Mission College
Health Occupations Department
3000 Mission College BLVD MS/19
Santa Clara, CA 95054
Performance Standards from the Health Occupations Student Handbook.

Performance Standards:
In compliance with the Americans with Disabilities Act, students must be, with reasonable accommodation, physically and mentally capable of performing the essential functions of the program. The Performance Standards adopted by the Health Occupations Department include the following:

Student must be able to:

- Be on your feet 6-8 hours at a time and perform activities that include reaching, balancing, carrying, pushing, pulling, stooping, bending and crouching;
- Lift up to 50 pounds;
- Lift and transfer adults and children from a stooped to an upright position to accomplish bed to bed, bed-to-chair and chair-to-bed transfers;
- Lift and adjust positions of bedridden patients, including pulling patients toward the head of the bed;
- Physically apply up to ten pounds pressure to bleeding sites or to chest in the performance of CPR using hands, wrists and arms;
- Maneuver in small spaces quickly and with ease;
- Perform fine motor skills that require hand-eye coordination in the use of small instruments, equipment, and syringes;
- Feel and compress tissues to assess for size, shape, texture, and temperature;
- Visually read calibrated scales;
- Perform close and distinct visual activities involving persons and paper work;
- Visually discriminate depth and color perception;
- Identify and distinguish odors;
- Respond and react immediately to auditory instruction, requests, signals, and monitoring equipment;
- Perform auditory assessments requiring the distinguishing of variances in sounds;
- Learn to communicate effectively, orally (face to face and on the phone) with correct pronunciation, and in writing, using appropriate grammar, vocabulary, and word usage with correct spelling, as well as medical terminology;
- Comprehend verbal and written directions, making correct notations and documentation, responding as directed;
- Make proper and timely decisions under stressful and emergency situations.
MISSION COLLEGE
HEALTH OCCUPATIONS DEPARTMENT
PHYSICAL EXAMINATION FORM

STUDENT PLEASE COMPLETE:
[X] NURSING ASSISTANT PROGRAM
[ ] PSYCHIATRIC TECHNICIAN PROGRAM
[ ] VOCATIONAL NURSING PROGRAM
[ ] RN PROGRAM
[ ] OTHER

PLEASE PRINT CLEARLY:

NAME: ____________________________ SEX: ____________________________

Last First M.I. M/F

STUDENT ID# ___________ BIRTHDATE: ___________ HOME PHONE: ___________ CELL: ___________

ADDRESS: __________________________________________

****************************************************************************************************************

Do you have a history of problems in the following areas? If you mark yes, please explain.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<tbody>
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Explanation: __________________________________________

List all serious illnesses/injuries and year(s) of occurrence:

List all operations and hospitalizations and indicate dates:

Medications you are presently taking:

****************************************************************************************************************

PHYSICIAN/HEALTH CARE PROVIDER: COMPLETE THIS AREA AND THE REVERSE OF THIS PAGE

VISION SCREENING

Glasses/Contacts: _______Yes _______No

Vision: Far(R) _______ (L) _______

Near(R) _______ (L) _______
STUDENT NAME: ____________________________
LAST  FIRST  M.I.

Height _______ Weight _______ B/P _______________ Pulse _______________

General  Skin:
EENT & Neck: Breasts:
Lungs: Heart:
Abdomen: Extremities & Spine:
Neurological: Mental/Emotional:
Diagnoses: __________________________________________

________________________________________

Treatment Required: __________________________________

________________________________________

Limitations:  

____ 1) Lifting
____ 2) Bending/Stooping
____ 3) Providing physical care to adults
____ 4) Standing/walking for 6-12 hours
____ 5) NONE

(Explain any limitations)
STUDENT NAME: ___________________________  LAST FIRST M.I. 

*Immunization records not adequate. The following Titer levels are required:

<table>
<thead>
<tr>
<th>TITERS</th>
<th>Date</th>
<th>Immune/Non-</th>
<th>Date Cleared (College use only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rubella Titer</td>
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<tr>
<td>Rubeola Titer</td>
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<td></td>
<td></td>
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<tr>
<td>Mumps Titer</td>
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<td></td>
<td></td>
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<tr>
<td>Varicella Titer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B Surface Antibody</td>
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</tbody>
</table>

*If titer indicates non-immunity proof of the following immunizations are required (1st injection is required prior to start date):

<table>
<thead>
<tr>
<th>Immunizations</th>
<th>Date</th>
<th>Date</th>
<th>Date Cleared (College use only)</th>
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</thead>
<tbody>
<tr>
<td>MMR (1,2)</td>
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<tr>
<td>Hepatitis B (1,2,3)</td>
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<td></td>
</tr>
<tr>
<td>Varicella (1,2)</td>
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</tbody>
</table>

* 2 step PPD (2nd PPD after 7 days of receiving the first PPD and within 3 weeks of 1st PPD) OR Quantiferon blood test
**Chest x-ray will only be accepted if proof of past positive PPD or Quantiferon is provided
*** TB surveillance form must be completed for all students regardless of results. All forms must be signed by healthcare provider

<table>
<thead>
<tr>
<th>Test for Tuberculosis</th>
<th>Date</th>
<th>Date</th>
<th>Date Cleared (College use only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD skin test (1,2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR Quantiferon blood test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest X-Ray (within 5 yrs.) if proof of past positive PPD</td>
<td>Chest X-Ray</td>
<td>Past Pos.</td>
<td></td>
</tr>
</tbody>
</table>

*Other Required Vaccines

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date</th>
<th>Date</th>
<th>Date Cleared (College use only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Flu Vaccine during flu season</td>
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<tr>
<td>Tdap (within 10 years)</td>
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</table>

Examiner: ___________________________ / ___________________________  Date

Please print or type name  Signature/Title  Date

_________________________  ___________________________
Phone number Address or Stamp
West Valley-Mission Community College District  
Student Health Services  
Tuberculosis Surveillance Form

Name: ___________________________ Date: ______________ ID: ___________________________

College: West Valley  Mission  Birth Date: ______________  Birthplace: ___________________________

When did you have your last skin test for TUBERCULOSIS? Date: ______________

What was the result?  Negative _____  Positive _____ mm

Where was the skin test performed? ____________________________________________

Did you have a QuantiFERON?  
What was the result?  Negative  Positive

When did you have your last chest x-ray for TUBERCULOSIS? Date: ______________

What was the result?  Normal _____  Abnormal _____

Where was the chest x-ray performed? ____________________________________________

Have you ever taken, or are you now taking, medication because your TUBERCULOSIS skin test was positive?  Yes _____  No _____

Have you received a BCG vaccination in the past year?  Yes _____  No _____

Please indicate “yes” or “no” to the following questions with regard to your experience during the past year:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you had any unexplained cough for over 2 to 4 weeks? If yes, please describe:</td>
<td></td>
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<tr>
<td>2. Have you or do you have any lung problems such as bronchitis, emphysema, asthma, or chronic cough?</td>
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<tr>
<td>3. Has anyone in your family, close friends or co-workers developed TUBERCULOSIS, or had their TUBERCULOSIS skin test change from a negative to positive reading? If yes, please describe:</td>
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<td>4. Have you ever coughed up blood? If yes, please describe:</td>
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<tr>
<td>5. Have you had any unexplained appetite loss or weight loss of more than (10) pounds within six (6) months? If yes, please describe:</td>
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<td>6. Have you had any unexplained sweating, especially at night? If yes, please describe:</td>
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<tr>
<td>7. Have you had any unexplained fevers? If yes, please describe:</td>
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<tr>
<td>8. Have you had any unexplained chest pain? If yes, please describe:</td>
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<tr>
<td>9. Has anyone in your family, close friends or co-workers developed any of the above-mentioned symptoms? If yes, please describe:</td>
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</tbody>
</table>

Patient’s Signature: ____________________________________________________________ Date: ______________

Referral for follow-up:  Yes: _____  No: _____  Date: ______________

Referred to: ________________________________________________

Health Care Provider’s Signature. Must Be signed, even, with negative PPD/Quantiferon.

Date: ______________  Phone: ( ) ____________________________