

**EL CENTRO COLLEGE
CENTER FOR ALLIED HEALTH AND NURSING
HEALTH OCCUPATIONS ADMISSIONS**

PHYSICAL EXAMINATION AND IMMUNIZATION REQUIREMENTS

In order to comply with the Texas Administrative Code (Title 25 Health Services, Rules 97.61-97.72) regarding immunization records for students enrolled in health-related programs, the following guidelines are now in force for applicants to El Centro College Health Occupations programs. Health Occupations program applicants must present the following documentation with their application materials.

IMPORTANT NOTE: Failure to submit the completed El Centro College Health Occupations physical examination form, immunization records (except for the third Hepatitis B injection) and a photocopy of the required CPR certification card will result in the applicant's disqualification from the applicant pool.

I. Physical Examination and Immunization Record Form

The completed physical form verified by a physician or nurse practitioner will document:

- The applicant's physical examination results which must be dated less than nine (9) months prior to the applicant's anticipated entry to the health occupations program; and,
- The date of each required immunization and/or date of a positive titer result for each.

NOTE: If immunization records have been recorded on separate documentation such as a hospital printout, health department card, office call invoice, etc., a clear photocopy of that documentation may be attached to the Physical Examination and Immunization Record form.

A. Physical Examination

The physical examination form must be completed by a physician or nurse practitioner and must document the applicant's medical history, health questionnaire, and results of a physical examination.

B. Tuberculosis Screening

An intradermal PPD (Mantoux) "skin" test is required for all applicants. **The PPD must be current within twelve (12) months of the applicant's anticipated entry into a health occupations program.** When accepted to a health occupations program, a student must be current on the screening and repeat the PPD every twelve (12) months for the duration of his/her enrollment in the program.

If the PPD indicates a positive reaction, documentation must indicate the induration of the test site and the applicant must also obtain a chest x-ray verifying the absence of active disease. **The chest x-ray must be current within one (1) year of program entry.** The chest x-ray will then be valid for two (2) years while the student is enrolled in the program. Individuals who have received the BCG injection or who have a history of tuberculosis or a positive PPD result should obtain a chest x-ray rather than the PPD.

C. Immunizations

An applicant must have completed the following immunizations according to the indicated guidelines and schedules. Documentation of a titer (blood test) **with specific lab values** verifying immunity or seropositivity is also acceptable for Measles, Mumps, Rubella, Varicella, and Hepatitis B.

1. **Measles** – Two (2) doses of measles (“rubeolla”) vaccine is required either in separate injections or in combination with mumps and rubella (“MMR”). **Both measles immunizations must have been received after January 1, 1968.** Individuals who were born prior to 01/01/57 are exempt from the measles immunization requirements.
2. **Mumps** – One (1) dose of mumps vaccine is required either in a separate injection or in combination with measles and rubella (“MMR”). Individuals who were born prior to 01/01/57 are exempt from the mumps immunization requirement.
3. **Rubella** – One (1) dose of rubella vaccine is required either in a separate injection or in combination with measles and mumps (“MMR”). There is **no exemption** from the rubella immunization requirement for individuals who were born prior to 01/01/57.
4. **Tetanus/Diphtheria/Pertussis (“Tdap”)**– One (1) dose of Tdap is required within the past ten (10) years. The documentation must clearly indicate that a **Tdap** was received. **NOTE:** A standard Tetanus or Tetanus/Diphtheria (Td) is not accepted.
5. **Varicella (chickenpox)** – Two (2) doses of varicella vaccine are required or documentation of a positive titer (blood test) with the lab values report. **NOTE: A statement from a physician or parent indicating the student’s previous varicella disease history is no longer accepted.**
6. **Influenza** – One dose of a flu vaccine is required within twelve (12) months of anticipated entry to a health occupations program.
7. **Hepatitis B series** – Three (3) doses of Hepatitis B vaccine are required per the timetable below:
 - Initial dose
 - Second dose one month after the initial dose
 - Third dose five months after the second dose

If an applicant fails to adhere to the above schedule, the series may have to be repeated.

NOTE: An individual must have received the first two Hepatitis B injections that documentation submitted with their application materials. *The third and final dose must be scheduled to be received prior to the start of the health occupations program.* Documentation of the third Hepatitis B injection or a positive Hepatitis B titer must be presented to the Health Occupations Admissions Office before the student will be registered for their program courses.

II. Exceptions

Exceptions from meeting certain immunizations requirements are allowed for such circumstances as medical conditions (i.e. pregnancy), religious beliefs, etc. **Applicants must present documentation as indicated below with their health occupations program application materials.** Requests for exceptions are reviewed on an individual basis.

In the case of immunization exemptions for pregnancy, all temporarily deferred immunizations must be received and documented with the Health Occupations Admissions Office no later than the start of the first semester of the individual's health occupations program.

NOTE: The inability to receive all required immunizations and health screenings required may prevent a student from entering a health occupations program.

A. Medical Exceptions

The applicant must present a statement **signed by their physician** with personal knowledge of the applicant's medical history. The statement must indicate in detail that a specific vaccine poses a significant health risk to the individual. If the statement requests exemption from the Hepatitis B series, the applicant must also complete a separate waiver form (available in the El Centro College Health Occupations Admissions Office) to accompany the physician's statement.

Unless the statement specifies that a lifelong condition exists, **the exemption is valid for one year** only from the date of the signed statement. In the case of pregnancy, **the exemption is valid only for the duration of the pregnancy** and the signed statement must indicate the anticipated date of delivery.

B. Exceptions Based on Religious Belief/Reasons of Conscience

The applicant must obtain an Exclusion Affidavit from the Texas Department of State Health Services **for each immunization in question** by submitting a written request and including the applicant's full name and date of birth. The written request must be mailed to the following agency:

Texas Department of State Health Services
Bureau of Immunization and Pharmacy Support
1100 West 49th Street
Austin TX 78756

The affidavit form will be mailed to the applicant who must complete and sign the form which must include the basis for the exception. The affidavit will be valid for a two-year period. The signed affidavit must be submitted with the applicant's Physical Examination and Immunization Record form.

NOTE: These exemptions may not be recognized by all hospital affiliates at which health occupations students are assigned for their clinical experiences. A student may be required to receive all screenings and immunizations for a health care facility.

III. El Centro College Health Center Services

The El Centro College Health Center does not offer immunizations, physical examinations, or chest x-rays; however, they can provide a list of physicians and clinics which offers physical examination at a reasonable cost. Immunizations may be obtained at urgent care clinics, some pharmacies, and at the Dallas County Health and Human Services office at 2377 N. Stemmons Freeway in Dallas.

NOTE: Applicants to health occupations programs are responsible for retaining a photocopy of all physical examination and immunization documentation for their personal records. Once this documentation has been submitted to the Health Occupations Admissions Office and the applicant is accepted to a health occupations program, the documentation becomes the sole property of the Health Occupations Admissions Office and **will not** be returned to nor photocopied for the applicant, their instructors, or any other party.

IMMUNIZATION RECORD AND PHYSICAL EXAM FORM

Once submitted, this document and any immunization or lab result attachments are considered official student records and will not be returned or photocopied for the student's use. Students should photocopy this form and any attachments to retain with their personal records.

DCCCD STUDENT ID NO. _____ DATE _____

NAME _____ BIRTHDATE _____
Last First MI Month / Day / Year

ADDRESS _____
Street City and State ZIP

TELEPHONE () _____ () _____
Home Business / Cell

I am applying to the _____ Program.

HEALTH QUESTIONNAIRE - (To be completed by the applicant)

Do you have any physical limitations which would affect your ability to lift, turn, or transfer patients? Yes _____ No _____

Do you have any limitations in use of your senses, such as in sight or hearing, which would limit your ability to practice a health profession? Yes _____ No _____

Do you have any other condition which might interfere with your ability to practice a health profession? Yes _____ No _____

If you have answered "yes" to any of the above, please explain your limitations in detail on a separate sheet of paper.

List any medications you have been taking on a regular or frequent basis during the past year.

TUBERCULOSIS SCREENING

Documentation requires an **official healthcare provider's signature** or verification from the Health Center.

Intradermal PPD (Mantoux) - within twelve (12) months of anticipated program entry unless previously positive.

Date _____ Results _____
Physician's Signature _____

Chest x-ray - within one (1) year of anticipated program entry if PPD positive (Must also include positive PPD verification above.)

Date _____ Results _____
Physician's Signature _____

IMMUNIZATIONS REQUIRED *

Dates of immunizations or dates of lab results with a copy of the lab values attached indicating seropositivity required. Each line requires a doctor's signature or verification from the Health Center. *

	Date of Immunization	If Seropositive, Date of Positive Titer (Attach Lab Results)	Doctor's Signature or Health Center Signature valid only if injection is given*
1. Measles – 2 doses since 01/01/68 <u>or</u> positive Titer; Exempt if born on or before 01/01/57	#1		
	#2		
2. Mumps – 1 dose if born on or after 01/01/57 <u>or</u> positive Titer; Exempt if born on or before 01/01/57			
3. Rubella – 1 dose <u>or</u> positive Titer			
4. Tetanus/diphtheria/pertussis (Tdap) – 1 dose within past 10 yrs.*			
5. Varicella (chickenpox) - 2 doses <u>or</u> positive Titer <u>or</u> documentation*	#1		
	#2		
6. Influenza – 1 dose within past 12 months			
7. Hepatitis B series ➤ 1 st initial dose ➤ 2 nd dose after 1 month ➤ 3 rd dose after 5 months			

* See attached immunization requirements documentation for details.

NOTE: Physical exam form will not be accepted without doctor's signature or health clinic verification for each immunization and TB screening. **No student may begin clinical rotations without verification of immunization status.**

PHYSICAL EXAMINATION: *To be completed by physician or nurse practitioner*

NAME _____ DATE _____
 Last First M.I./Other

HEIGHT _____ WEIGHT _____ TEMP _____ BLOOD PRESSURE _____ SEX _____

VISION _____ GLASSES _____ CONTACT LENSES R _____ L _____

HISTORY: Include any significant information regarding previous medical and surgical conditions, and use of alcohol and/or drugs.

GENERAL APPEARANCE:

PHYSICAL EXAMINATION (cont.)

Normal	Check each item in appropriate column	Abnormal	Describe every abnormality in detail (attach sheet if necessary)
	Eyes - ears - nose – throat		
	Mouth - teeth – neck		
	Thyroid		
	Heart and vascular		
	Lungs		
	Abdomen and viscera		
	Hernia		
	Scars		
	Back, vertebrae		
	Genitalia (optional)		
	Pelvis with Pap Smear (optional)		
	Rectal, anus (optional)		
	Extremities		
	Skin		
	Neurological		

LABORATORY DATA: Specific lab findings, when necessary for diagnostic purposes.

<u>Name of Test</u>	<u>Results</u>
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PHYSICIAN RECOMMENDATION

Based upon your physical examination, is the applicant free of any restrictions in his/her ability to turn and/or move heavy objects? If "no," please describe: Yes ____ No ____

Is the applicant able to see and hear adequately to practice a health care profession? If "no," please explain: Yes ____ No ____

Is the applicant free of any pathological conditions either physical or mental that would interfere with the practice of a health profession? If "no," please describe: Yes ____ No ____

Signature of Physician or Nurse Practitioner

Date

Printed Name of Physician or Nurse Practitioner

Address of Physician or Nurse Practitioner