Health Occupations Division

Health & Safety Packet for Incoming Students

This packet has been designed to help Health Occupations students comply with CPR and health/physical documentation requirements. Please take this packet to your health care provider or the Napa Valley College Student Health Center along with any personal health documentation you may have. This packet will help ensure your provider knows exactly what is needed for you to become compliant with our program. If you are a current registered student, you can obtain the physical exam, and TB testing at low or no cost at the Napa Valley College Student Health Center. To contact the Student Health Center in building 2250, call 707-256-7780 or visit their web page at: Student Health Center (napavalley.edu)

Students enrolled in the Health Occupations programs MUST provide documentation of immunity as required by the California Department of Public Health, Napa Valley College, and affiliated clinical sites. If Health and Safety requirements (including CPR, titers, flu, TB clearance, physical exam) and any other stated requirements are not current and on file, you will not be allowed to go to clinical, therefore jeopardizing your ability to meetobjectives and continue in the program.

You will need to keep a document portfolio with your original documentation for yourself. Instructions for use of background check and drug testing will be provided at the orientation meeting.

Please note: Your Physical/Medical Health History must be completed on the NVC documentation.

The Health Occupations Division of Napa Valley College looks forward to working with you.

NAPA VALLEY COLLEGE
HEALTH OCCUPATIONS- Documentation Checklist

Name: Last______________________________First____________________________Date_______________

SUBMIT COPIES OF ALL OF THE FOLLOWING DOCUMENTATION WITH THIS PACKET		
√ Done	Requirements	Description of what you need / Special Instructions
	Tetanus-Diphtheria-Pertussis (Tdap)	Booster must be **within the last 8 years**
	Measles	**POSITIVE TITER (blood test) for each component** *Females should not be given the MMR vaccine if pregnant or if there is any reason to suspect pregnancy. Because a risk to the fetus from administration of these live virus vaccines cannot be excluded for theoretical reasons, women should be counseled to avoid becoming pregnant for 28 days after vaccination with measles or mumps vaccines or MMR or other rubella-containing vaccines.*
	Mumps	
	Rubella	
	Hepatitis B Surface Antibody	**POSITIVE TITER (blood test)**
	Varicella • History of Chicken Pox is *not* acceptable.	**POSITIVE TITER (blood test)** *Females should not be given the Varicella vaccine if pregnant or if there is any reason to suspect pregnancy. Because a risk to the fetus from administration of live virus vaccines cannot be excluded for theoretical reasons, women should be counseled to avoid becoming pregnant for 28 days after vaccination.*
	Tuberculosis (TB) PPD Skin Test • Students must have an **annual TB test** according to the following schedule: ***If entering the program in:*** **Fall** – Please test in August **Spring** – Please test in January	**NEGATIVE TEST RESULT** **If TB test is or has ever been positive:** do not be retested – a chest x-ray is required. For positive TB skin test, provide the date of the test, any treatment received, and documentation of a negative chest x-ray report within the last 12 months**. If you have a record of positive PPD, you must provide a chest x-ray report with no abnormalities *AND* submit an Annual Symptom Review (ASR).** An ASR will be due annually for anyone with a negative chest x-ray. Chest x-ray will need to be repeated every two years while in the program, ***or -*** you may submit a negative QuantiFERON-TB Gold test. This will be accepted every year **WITH** an Annual Symptom Review (ASR). **Tine test is not acceptable**
	Seasonal Influenza Vaccination Due annually	If you are not able to receive the influenza vaccine due to medical or religious reasons, you will need to sign a declination form *each* season.
	CPR	**American Heart Association- Basic Life Support for Health Care Provider ONLY**
	Physical & Health History	Use documents from this packet ONLY. Physical must be completed within 3 months of the start of the program.
	COVID Vaccine & Booster	If possible, please submit COVID Card or the Smart Health Card.

These requirements are subject to change depending on clinical facility requirements.

What is a Titer? A titer is a blood test taken to prove immunity to various diseases. As said on the previous page, we are now requiring all prospective students to have titers completed. IF titers are negative, we will instruct you on the process of how to obtain positive titers. The process for some can take up to 9 months, so please get your titers early!

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What to Do if You Have a Negative Titer:

Measles, Mumps and Rubella (MMR): Depending on your vaccination history and how low your immunity level is – you may need up to 2 MMR boosters spaced 28 days (4 weeks) apart.
A subsequent titer is required a minimum of 28 days (4 weeks) after the final booster.

Varicella: Depending on your vaccination history and how low your immunity level is – you may need up to 2 Varicella boosters spaced 28 days (4 weeks) apart. A subsequent titer is required a minimum of 28 days (4 weeks) after the final booster.

Hepatitis B Surface Antibody test: If no ***Adult*** series of Hepatitis B vaccinations has ever been started, you must complete the adult series of 3 vaccinations, spaced at 0, 1 and 6 months. A subsequent titer is required at least 4 weeks but no more than 8 weeks after 3rd shot.

HEALTH OCCUPATIONS PROGRAMS HEALTH & SAFETY COVER PAGE

PLEASE PRINT ALL INFORMATION

Name: Last_________________________________First_______________________________MI______________

Address______________________________________City__________________________Zip_ Home Phone:

_____________________________________Cell Phone:_______________________Date of Birth ____________

NVC Student ID:_______________________Email:____

Program Entering: ☐ ADN ☐ EMS ☐ LVN ☐ PTEC ☐ RC

Semester Starting: Fall 20_____ Spring 20_____

Health & Safety and CPR Documentation Requirements

Please submit COPIES of the following documentation. Keep originals for yourself.

☐ **CPR card –** E-card or paper card. It must be **American Heart Association Basic Life Support for Health Care Provider ONLY.** Classes offered at Napa CPR at www.napacpr.com.

☐ **Physical and health history forms (must use forms from this packet) -** Must be within 3 months of the start of the program. Health facility must also verify with their business stamp on page 1 of physical assessment document. If using Student Health Center for Physical- See instructions in packet.

☐ **Tetanus-Diphtheria-Pertussis Booster (Tdap) - within last 8 years of start of program.**

☐ **MMR- POSITIVE TITER (all components)**

☐ **Hepatitis B- POSITIVE SURFACE ANTIBODY TITER**

☐ **Varicella- POSITIVE TITER**

☐ **NEGATIVE Tuberculosis (TB) PPD Test (or Chest X-ray and Annual Symptom Review if PPD test is POSITIVE); Quantiferon Gold Test is acceptable (with Annual Symptom Review).**

If entering the program in: **Fall-** TB (PPD) Please test in August
Spring- TB (PPD) Please test in January

☐ **Seasonal Flu- Due annually**

☐ **COVID Vaccine & Booster**

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:

Name:____Relationship:_________________________________

Address:______________________________________City:_________________________Zip:______________

Home Phone:____________________________________Cell Phone:_____________________________________

Signing this form gives Health Occupations permission to share all contact, CPR, and health information with affiliated clinical sites.

Student Signature____ **Date**_____________________________

NVC office USE ONLY: Reviewed by:____Date:_____________________

10/23

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PHYSICAL ASSESSMENT

Must be completed by a Physician, Nurse Practitioner or Physician's Assistant

PROGRAM ENTERING: _____**ADN** _____**PTEC** _____**RC** _____**LVN** _____**PARAMEDIC**

Name:____ Date of Physical: _________________________________
(Must be within 3 months of starting the program)

Date of birth:____________________________________ Age: _______________

Height:________________Weight:__ **Vision**: Within Normal Standards ☐ **Hearing**: Within Normal Standards ☐

Blood Pressure:_________/________ Not within Normal Standards ☐ Not within Normal Standards ☐

Pulse: ____________________ Accommodations: ________________ Accommodations: ________________

	Normal	Comments
eyes		
ears, nose, throat		
mouth and teeth		
neck		
cardiovascular		
chest and lungs		
abdomen		
skin		
genitalia – hernia		
musculoskeletal: ROM, strength, etc.		
neck ☐ shoulders ☐ arms ☐		
hands ☐ back ☐ hips ☐		
knees ☐ feet ☐		
neurological		
other:		

Is this applicant now under treatment for any medical or emotional condition?

Yes ☐ No ☐ If yes, please summarize: ____

____

____

____

Does this applicant have any condition that would preclude participation in a clinical healthcare provider program?

Yes ☐ No ☐ If yes, please describe any limitations or necessary program adaptations: ____________________

____

Health Provider's Printed Name: ____________________________________

Health Provider's Facility Name: ____________________________________

Health Provider's Facility Address: ____________________________________

Health Provider's City, State, ZIP: ____________________________________

Health Provider's Telephone: ____________________________________

Health Provider's Business Stamp:

Health Provider's Signature:____**Date:** ______________________________

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MEDICAL HEALTH HISTORY

(To be completed by student **prior** to physical exam)

Bring this completed form with you to your appointment when you have your physical examination done.

Please check if you have or have had any of the following:

_____ Frequent/severe headache/migraines
_____ Seizure disorder/epilepsy
_____ Dizziness
_____ Repeated fainting
_____ Problems with vision
_____ Problems with hearing
_____ Asthma
_____ Bronchitis
_____ Pneumonia
_____ Frequent cough
_____ Recurrent sinus infections
_____ Exposure to tuberculosis/positive PPD (TB skin test)
_____ Shortness of breath/difficulty breathing
_____ Chest pain with activity
_____ Heart disease/condition/murmur
_____ Blood pressure problems
_____ Women's health problem/birth control
_____ Stomach or bowel problems
_____ Cancer

______ Hernia/rupture
______ Unexplained weight loss/gain
______ Skin problems
______ Swollen glands for longer than 2 weeks
______ Cigarette smoking/chewing tobacco
______ Back injury or problems
______ Numbness or decreased feeling hands, feet
______ Thyroid problem
______ Urinary tract problems
______ Varicose veins
______ Depression
______ Blood sugar problems
______ Anxiety/panic attacks/depression
______ Other psychiatric problems
______ Alcoholism/liver disease
______ Hospitalization/surgery
______ Abusive relationship
______ Chicken pox
______ Other ________________________

Limited or painful movement or use of:

_____ neck   _____ shoulder (s)   ______ elbow(s)   _____ wrist(s)   _____ hand(s)
_____ hip(s)   _____ knee(s)   ______ ankle(s)   _____ feet   _____ back

Please explain any items checked: (Write N/A if not applicable)

____

____

Please list all medications which you currently take (prescription, over the counter including herbal): (Write N/A if not applicable)

____

____

Please list any allergies, which you have: (Write N/A if not applicable)

____

Have your activities been restricted during the past 5 years? Yes ☐ No ☐ if yes, please explain:

____

____

If you have a documented disability that causes educational limitations that require accommodations, contact the Disabled Students Program and Services (DSPS) at (707) 256-7234 to make an appointment.

Student signature:________________________________ **Date:** ________________________

Your visit to the Student Health Center will be much faster if you fill out your forms <u>before</u> your appointment.

Here are the steps:

1. Call the Student Health Center (707) 256-7780 to make an appointment. Be sure to tell their office what the appointment is for.

2. Upon making your appointment an email will be sent to you with the form(s) needed for your appointment.

3. Fill out the form(s) prior to your appointment.

Forms can also be found online at napavalley.edu/healthcenter

If you have any problems, you can call us at (707) 256-7780 for help.