



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 \(napavalley.edu\)](http://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 meet objectives 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 <u>COPIES</u> 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 <u>within the last 8 years</u>
	Measles	POSITIVE TITER (blood test) for each component <i>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.</i>
	Mumps	
	Rubella	
	Hepatitis B Surface Antibody	POSITIVE TITER (blood test)
	Varicella • History of Chicken Pox is <u>not</u> acceptable.	POSITIVE TITER (blood test) <i>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.</i>
	Tuberculosis (TB) PPD Skin Test • Students must have an annual TB test according to the following schedule: <i>If entering the program in:</i> Fall – Please test in July 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 <u>AND</u> 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 two years WITH an Annual Symptom Review (ASR). <u>Tine test is not acceptable</u>
	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 <u>each</u> 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!

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 July
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: _____



**NAPA VALLEY COLLEGE
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 <input type="checkbox"/> shoulders <input type="checkbox"/> arms <input type="checkbox"/>		
hands <input type="checkbox"/> back <input type="checkbox"/> hips <input type="checkbox"/>		
knees <input type="checkbox"/> feet <input type="checkbox"/>		
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:** _____



NAPA VALLEY COLLEGE
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:

<input type="checkbox"/> Frequent/severe headache/migraines	<input type="checkbox"/> Hernia/rupture
<input type="checkbox"/> Seizure disorder/epilepsy	<input type="checkbox"/> Unexplained weight loss/gain
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Skin problems
<input type="checkbox"/> Repeated fainting	<input type="checkbox"/> Swollen glands for longer than 2 weeks
<input type="checkbox"/> Problems with vision	<input type="checkbox"/> Cigarette smoking/chewing tobacco
<input type="checkbox"/> Problems with hearing	<input type="checkbox"/> Back injury or problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Numbness or decreased feeling hands, feet
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Thyroid problem
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Urinary tract problems
<input type="checkbox"/> Frequent cough	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Recurrent sinus infections	<input type="checkbox"/> Depression
<input type="checkbox"/> Exposure to tuberculosis/positive PPD (TB skin test)	<input type="checkbox"/> Blood sugar problems
<input type="checkbox"/> Shortness of breath/difficulty breathing	<input type="checkbox"/> Anxiety/panic attacks/depression
<input type="checkbox"/> Chest pain with activity	<input type="checkbox"/> Other psychiatric problems
<input type="checkbox"/> Heart disease/condition/murmur	<input type="checkbox"/> Alcoholism/liver disease
<input type="checkbox"/> Blood pressure problems	<input type="checkbox"/> Hospitalization/surgery
<input type="checkbox"/> Women's health problem/birth control	<input type="checkbox"/> Abusive relationship
<input type="checkbox"/> Stomach or bowel problems	<input type="checkbox"/> Chicken pox
<input type="checkbox"/> Cancer	<input type="checkbox"/> Other _____

Limited or painful movement or use of:

<input type="checkbox"/> neck	<input type="checkbox"/> shoulder(s)	<input type="checkbox"/> elbow(s)	<input type="checkbox"/> wrist(s)	<input type="checkbox"/> hand(s)
<input type="checkbox"/> hip(s)	<input type="checkbox"/> knee(s)	<input type="checkbox"/> ankle(s)	<input type="checkbox"/> feet	<input type="checkbox"/> 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 before 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.