SADDLEBACK COLLEGE
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MANDATORY HEALTH ASSESSMENTS AND IMMUNITY STATUS REQUIREMENTS FOR THE MLT PROGRAM

Instructions for our Students for Program Clearance

- All students must have a physical completed for admission into the program. You may make an appointment with your Health Care Provider or the Student Health Center at **(949) 582-4606** for your physical. You must be registered and currently enrolled to make an appointment with the Student Health Center.
- It is **necessary** for you to bring copies of **ALL** of your immunization records to the Student Health Center; if you do not have copies it will be necessary to have blood tests to determine immunity.
- If you need titers drawn for immunizations this may take 2 weeks to complete this process, depending upon availability of appointments and your requirements. You must complete the required health assessments and establish immunization status by due date.
- **If your physical is completed by your Health Care Provider, you MUST make an appointment with the Student Health Center for FINAL sign-off.**

Costs at the Student Health Center	
Physical Exam	$15 Limited-(Program Clearance)
	$25 DMV or Complex

Required Immunization/Laboratory Tests:

You **MUST** provide documentation of immunity to the following diseases by either official medical/vaccination records or blood testing:

- Measles (Rubeola)
- Mumps
- Rubella
- Varicella
- TDAP
- Hepatitis B Surface Antibody
- Varicella IgG

Costs at the Student Health Center	
Vaccines	Blood Tests
MMR $70 /dose	MMR titer $35
Varicella $130 /dose	Varicella titer $15
(Need 2 doses) or immunity	Hepatitis B titer $15
Hepatitis B $70/dose (need 3)	
TDAP $70	
Influenza Vaccine $20	

Required Tuberculosis Skin Testing:

- **Two-step** TB skin testing is required if you have not had a TB skin test within the past year.
- **One-step** TB skin testing is acceptable if you can provide documentation of TB testing within the past year.
- Proof of negative TB or current chest X-Ray within 2 years.

Costs at the Student Health Center	
One & Two-step TB Test- Student	$20
Community member TB	$25

Immunization with the following vaccine is highly recommended but may be declined; but you must sign a declination form to be kept in your file in the division office.

- Hepatitis B

Hospitals are now requiring the seasonal flu shot. IF you decline you must wear a mask at all times in the hospital while doing patient care.

Revised 4/2017

The student is required to return this packet to our Student Health Center for final sign-off. We thank you for your assistance

Immunization and TB Testing Records

Applicant Name: _____ Date of Birth: _____

- *Attach copies of immunization records, laboratory results and radiological reports (if indicated) and submit to the Student Health Center.*

Required Immunizations	Date	Date
Mumps (2 doses required)		
Rubeola (2 doses required)		
Rubella (2 doses required)		
or		
MMR (2 doses* required)		
Varicella (2 doses required)		
TDap		

* CDC recommends a single dose of MMR for persons born before 1957.

Or immunity confirmed by laboratory testing:	Date	Results
Mumps IgG		
Rubella IgG		
Rubeola IgG		

Laboratory Testing:	Date	Results
Hepatitis B Surface Antibody*		
Varicella Zoster IgG		

*May waive if applicant receives recommended Hepatitis B Vaccine series.

TB Skin Test (Mantoux): Check one→ □ **One-step indicated** □ **Two-step indicated**

1st Step	Date given:	Date read:	Results: _____mm
2nd Step	Date given:	Date read:	Results: _____mm

Chest X-ray (required if tuberculin skin test is positive):

Date of CXR: _____Results of CXR: _____

Other Vaccines:	**Date**	**Date**	**Date**
Hepatitis B			
Influenza			
Td			

Applicant declines:	Applicant must initial
Hepatitis B Vaccine Series	
Influenza Vaccine	

Applicant's signature /date _____

Health Care Provider (Print Name)_____

Signature_____ Date:_____

Evaluation and Recommendation

Applicant Name: _____ Date of Birth: _____

To the Applicant: Complete the Medical History below before your appointment:

Have you ever had or do you currently have:	NO	Yes (explain)
Diminished hearing		
Diminished vision		
Shortness of breath on exertion		
Pain, pressure or tightness in the chest		
Fainting spells, dizziness or blackouts		
Excessive weakness or fatigue		
Epilepsy or seizures		
Severe depression and/or anxiety		
Addiction to narcotics, alcohol or other illegal drugs		
Low back pain or a "slipped disc"		
Joint pain		

Medical Documentation:

Vision: OD 20/___ OS 20/___ Check one: □ Corrected □ Uncorrected

Areas evaluated	**Normal**	**Abnormal/Findings**
Eyes		
Ears, Nose, Throat		
Heart, Lungs		
Spine		
Range of Motion: Back/Extremities		
Neurological Status		
Emotional Status		

Check one:

□ I certify this student met the physical and immunization standards described in the attached Advisory Statement and Instructions for the Physician or other Licensed Health Care Provider and is qualified for participation in the Saddleback College Associate Degree Nursing Program.

□ Conditionally qualified for program placement: Student must obtain written medical clearance from a private physician or other specialist for the following reasons:

_____

_____

□ Not qualified for program placement for the following reasons:

_____

_____

_____

Physician's signature/ and date

Physician's Office Stamp