**IMMUNIZATION, CPR, AND PHYSICAL EXAM REQUIREMENTS**

**SCHOOL OF HEALTH SCIENCES PROGRAMS**

The immunization requirements on this form are REQUIRED of all individuals applying to the School of Health Sciences program. Students must upload their **ORIGINAL** health documentation to [www.SurScan.com](http://www.SurScan.com) (the Dallas College Immunization Form is not original documentation). Use client code *Dallas College* for account set up.

All Vaccine/Immunization records must include full dates i.e. month/day/year & health care providers’ signatures. Health care provider initials may be considered sufficient if the document is on a health care provider’s letterhead including the name & address of the practice.

Immunization records should include date administered, vaccine administered, injection site, specific dose, route, vaccine manufacturer, lot number, and expiration along with provider and student information. Lab reports required on all titers. Based on clinical placement requirements, a titer may be required after an initial equivocal or negative result and repeat series of vaccinations. **School records will NOT** **be accepted**. Immunization records submitted without thorough documentation will not be accepted at any clinical site and students will be required to repeat vaccines or obtain titers in lieu of vaccines if applicable.

1. **MMR**
   1. Documentation of 2 vaccines **or** positive Immunoglobulin G (IgG) antibody titers to Measles (Rubeola), Mumps and Rubella.
   2. If titer is negative or equivocal, series must be repeated.
2. **Varicella**
   1. Documentation of 2 vaccines **or** positive Immunoglobulin G (IgG) antibody titers to Varicella
   2. If titer is negative or equivocal, series must be repeated.
3. **TDap**
   1. Documentation of vaccine within the past 10 years
4. **Influenza Vaccine (Seasonal Flu)**
   1. Documentation of current seasonal flu vaccine by October 1st
5. **Hep B (Students involved in Direct Patient Care)**
   1. Hepatitis B series (2 or 3 dose) (Hepatitis A/B combo series accepted) **AND**
   2. Positive Hepatitis B Surface Antibody titer. If Hep B vaccine documentation cannot be found, a positive titer will be sufficient.
   3. If titer is negative or equivocal, series must be repeated and a 2nd titer is drawn; upload results of both titers and vaccination proof.
6. **TB Testing**
   1. TB skin test, QuantiFeron Gold (blood test) or T-Spot is accepted.
   2. If screen results are positive (+), those results and documentation of a chest x-ray is required and must be negative for active disease.
   3. TB screening must be within 12 months of program application and must be updated every year

**A valid physical exam is required at entry into all Health Sciences programs and must be submitted on the attached Physical Exam form.**

**CPR: Annual Basic Life Support for Health Care Providers CPR certification. CPR certification from the American Heart Association (AHA), Red Cross or Military approved mechanism is the only approved CPR course and must be face to face or hybrid training. Completely online courses are not accepted. Some clinical sites may only accept AHA CPR cards.**

**PHYSICAL EXAM FORM**

**You must use this physical exam form. The form must be completed by a physician or nurse practitioner.**

**Applicant Full Name** **Date of Birth**

**Email Address** **Student ID #**

**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:**

|  |  |  |  |
| --- | --- | --- | --- |
| Normal | Check each item in appropriate column | Abnormal | Describe every abnormality in detail (attach additional sheet if necessary). |
|  | Eyes-ears-nose-throat |  |  |
|  | Mouth-teeth-neck |  |  |
|  | Thyroid |  |  |
|  | Heart and Vascular |  |  |
|  | Lungs |  |  |
|  | Abdomen and Viscera |  |  |
|  | Hernia |  |  |
|  | Scars |  |  |
|  | Back, vertebrae |  |  |
|  | Extremities |  |  |
|  | Skin |  |  |
|  | Neurological |  |  |

**Physician Recommendation**

Based upon your physical examination, is the applicant free of any restrictions in his/her ability Yes \_\_\_\_ No \_\_\_\_

to turn and/or move heavy objects? If “no,” please describe:

If the applicant able to see and hear adequately to practice as a health care professional? Yes No

If “no,” please explain:

Is the applicant free of any pathological conditions either physical or mental that would interfere Yes No

With the practice of a health care profession? If “no,” please describe:

**PHYSICIAN OR NURSE PRACTITIONER SIGNATURE IS REQUIRED FOR THIS FORM TO BE ACCEPTED:**

Signature of Physician or Nurse Practitioner Date

Printed Name of Physician or Nurse Practitioner

Phone Number ( )

Address of Physician or Nurse Practitioner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICAL EXAM FORM – Page 2**

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, TX \_\_\_\_\_\_\_\_\_\_\_\_

Phone: (C) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Questionnaire: (To be completed by applicant):**

Yes: \_\_\_\_\_ No: \_\_\_\_\_ Do you have any physical limitations that 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 that might interfere with your ability to

practice in the health professions?

If you answered ‘Yes’ to any of the above, please explain your limitations in detail:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications you take on a regular basis or on a frequent basis during the past twelve months:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History: Include any significant information regarding previous medical, surgical, psychiatric conditions and

use of alcohol and/or drugs.:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_