EL PASO COMMUNITY COLLEGE PROCEDURE

For information, contact Institutional Effectiveness: (915) 831-6740

FFAA-1 **Immunization, Tuberculosis Testing and Physical Examination Requirements for Health Career and Nursing Students**

APPROVED: November 5, 1982 **REVISED**: June 8, 2012
Year of last review: 2021
AUTHORIZING BOARD POLICY: FFAA

Classification: Administrative
Vice President or Associate Vice President: Vice President of Instruction and Workforce Education
Designated contact: Dean or Director of the Program

OBJECTIVE: To establish guidelines under which immunizations, tuberculosis testing, and physical examination are to be required and to be maintained.

PROCEDURE: As a general condition for admission to El Paso County Community College District, no documentation regarding immunization, tuberculin testing or physical exam will be required, although applicants will be encouraged to ensure that their immunization records are complete and up to date. However, special conditions exist upon admissions to health careers programs which require a record of immunization, tuberculin testing and physical examination (see the forms and letter templates attached to this procedure, FFAA-1 *Immunization Tuberculosis Testing and Physical Examination Requirements for Health Career and Nursing Students*).

I. Health Careers Students Admission Requirements

A. In accordance with current Center for Disease Control and Texas Department of State Health Services (DSHS) guidelines (credit and CE) as well as clinical affiliate requirements, upon admission to a specific program within the Health Careers and Nursing Programs, students will be required to submit evidence of adequate levels of immunity immunization against the following diseases or verifiable titer demonstrated through laboratory tests:

1. Tdap with periodic Tetanus boosters
2. Diphtheria
3. Measles
4. Mumps
5. Rubella
6. Varicella
7. Tuberculosis (PPD or Tine, or Chest X-ray)
8. Hepatitis B Vaccine is required for healthcare professionals, including students.
9. Meningococcal vaccine is strongly required for all college students effective January 2012. It is required for all college students unless they are exempt for one of the following reasons:

   A student is not required to submit evidence of receiving the vaccination against bacterial meningitis or evidence of receiving a booster dose if:

   a. the student is 30 years of age or older by the first day of the start of the semester; or
   b. the student is enrolled only in online or other distance education courses; or

***Note: The word "faculty" denotes instructors, counselors and librarians.**

c. the student is enrolled in a continuing education course or program that is less than 360 contact hours, or continuing education corporate training; or
d. the student is enrolled in a dual credit course which is taught at a public or private K-12 facility not located on a higher education institution campus; or
e. the student is incarcerated in a Texas prison.

10. Influenza is mandatory

11. If age 65 or older, a Pneumococcal vaccine is recommended.

12. If age 60 or older, a Herpes Zoster is recommended. This can substitute for the above listed Varicella.

B. Health Careers Student - Maintenance Requirement

Maintenance of the following tests, associated with tuberculosis, are necessary for continuation in the specific program clinical areas as outlined in the affiliation agreements as follows:

1. The PPD or TB skin test and or TB assessment from a U.S. licensed healthcare provider must be updated every year.

2. Chest X-rays completed upon admission to the program that are negative will not need to be updated during continuous enrollment at EPCCCD for five years unless documented exposure or symptoms of active TB occurs as indicated.

3. Chest X-rays will be required if the student becomes symptomatic for TB. They will also be referred to the City Health Department for follow-up.

4. Students who have a negative PPD which converts to positive must have a follow up Chest X-ray. If the x-ray is documented negative, the student will then follow I. B. 2 and 3, above.

C. Physical Exam for Health Careers Programs

1. The initial physical exam must be completed during admissions or upon official acceptance into health career programs. It must be performed by a healthcare provider (PA, NP MD, DO) licensed to practice in the United States.

2. The Physical exam must be updated every 3 years unless otherwise indicated.

II. Exemptions

A. Medical Contraindications

The student must present a written statement from a physician, licensed to practice in the United States, that the immunizations would be injurious to the health and well-being of the applicant, any member of the applicant's family or household, and/or the applicant's unborn child.

B. Religious Conflicts

The student must present a sworn affidavit signed by the applicant, or if a minor, by the applicants parent or guardian, stating that the immunizations conflict with the tenets and practice of a recognized church or religious denomination of which the applicant is an adherent or member. This exemption does not apply in times of an emergency or epidemic declared by the Commissioner of Health.

C. Allergy to Influenza vaccine or declination of the Influenza vaccine will require the use of a mask during clinical in accordance to affiliate policy.

III. Faculty*/Staff

All above guidelines also apply to health-related faculty and staff in clinical assignments.

DECLINATION OF ANNUAL INFLUENZA VACCINATION

INFLUENZA (FLU) is a serious contagious respiratory disease that can cause fever, chills headache, cough, sore throat, tiredness and muscle aches. It can lead to pneumonia, hospitalization and even death.

I understand that due to my occupational exposure, I may be at risk of acquiring influenza infection.

The Influenza Vaccination has been recommended for me and all healthcare workers to prevent influenza disease and its complications, including death.

If I contract influenza, I may spread it to my patients, other healthcare workers, and my family because I will shed the virus for 24-48 hours before my symptoms appear.

I understand that influenza can result in serious infection, particularly in persons at high risk for influenza complications.

I understand I cannot get the influenza disease from the influenza vaccine.

I have received education about the effectiveness of influenza vaccination as well as the adverse events.

However, despite these facts, I decline influenza vaccination at this time.

I understand that by declining this vaccine, I continue to be at risk of acquiring influenza, potentially resulting in transmission to my patients, I furthermore understand I must wear a mask during my clinical experiences in accordance with affiliate procedure.

If in the future I want to be vaccinated with the influenza vaccine, I can receive the vaccine if the vaccine is still available.

Reason for declining the vaccine at this time is (for survey purposes only):

Allergic reaction	I'm healthy, so no risk	I become ill when vaccinated
I'm concerned about side effects	Fear of needles	Not interested
Don't know enough about it	Against Medical Advice	

_____

Student Signature: _____ Date: _____

Witness Signature _____

VERSION A:

P.O. Box 20500
El Paso, Texas 79998
915-831-2000

Dental Assisting
Dental Hygiene
Emergency Medical Technology/
Medical Assisting Technology/
Nursing
Physical Therapist Assistant
Radiologic Technology
Radiation Therapy
Respiratory Care Technology
Surgical Technology
Diagnostic Medical Sonogram
CNA Massage Therapy
Vocational Nursing

Dear Healthcare Provider:

A prospective student of the Health Career Programs at El Paso Community College will be seeing you for a Physical examination. Our physical exam form (copy attached) asks that you verify this person's ability to carry out the often stressful and physically demanding schedule the program requires in the hospital or community setting.

Most Health Career Programs are rigorous ones in which the student carries a minimum of 40 hours of classroom and clinical activities in addition to homework and study time. Physical activities generally require both gross and fine manipulative skills to patient or student. The activities increase in numbers of patients, numbers of clinical hours and complexity throughout the program.

Additionally, the student may be caring for all types and ages of patients, including prenatal, newborn, oncologic, geriatric, etc., and therefore must be free of any disease or condition that could be dangerous to others or the student.

Specific physical activities and patient contact vary depending on which program the student is in. This student will be entering a program which has:

__X__ 1. High patient contact and high level of physical activity.

_____ 2. Low patient contact and low to moderate level of physical activity.

Thank you for your thorough physical examination of this prospective student.

7/2011

VERSION B:

P.O. Box 20500
El Paso, Texas 79998
915-831-2000

Allied Community Health Services
Health Information Technology
Medical Transcription
Medical Coding
Medical Laboratory Technology
Phlebotomy Technology

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7/2011

PPD Skin Test Interpretation or Chest X-ray Annual Follow-up for Health Career Student and Faculty

Name of Patient _____ Date of Birth_____

Organization administering questionnaire _____ Date _____

Skin test interpretation depends on two factors:

- Measurement in millimeters (mm) of the induration
- Person's risk of being infected with TB and progression to disease if infected

The table below should be used to determine whether the skin test reaction is Positive. A person with a positive reaction should be referred for a medical evaluation for latent TB infection and appropriate follow-up and treatment if necessary. A measurement of 0mm or a measurement below the defined cut point for each category is considered negative.

Place a mark in the appropriate box:	**Yes**	**No**
Induration of ≥ 5mm is considered positive in: Is the individual human immunodeficiency virus (HIV) infected? Has the individual had recent contacts of TB case patients? Has the individual been found to have fibrotic changes on chest radiograph consistent with prior TB? Has the individual had an organ transplant or are you immunosuppressed (e.g., receiving the equivalent of ≥ 15mg/d of prednisone for 1 month or more)?		
Induration of ≥ 10mm is considered positive in: Is this individual a recent immigrant (within the last 5 years) from Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia? Is the individual an IV drug user? Is the individual a resident or employee of: *Prisons and jails *Nursing homes and other long-term facilities for the elderly *Hospitals and other health care facility *Residential facility for AIDS *Homeless shelters Does this individual have: *silicosis *malignancies (carcinoma of head, neck or lung) *diabetes mellitus *weight loss of ≥ 10% of ideal body weight *chronic renal failure *gastrectomy or jejunoileal by pass *hematologic disorder (leukemia, lymphoma) Is the individual less than 5 years old?		
Induration of ≥ 10mm is considered positive in: In all persons who have had the PPD Skin Test		

Signature of Healthcare Provider: _____ Date: _____

Contact Information: _____

REPORT OF HEALTH EVALUATION

For Students in Health Occupations Programs

For College Procedure FFAA-1: *Immunization*
Tuberculosis Testing and Physical Examination
Requirements for Health Career and Nursing Students

LAST NAME (PLEASE PRINT)	FIRST NAME	MIDDLE	PROGRAM	DATE OF ENTRY

HOME ADDRESS (Number and Street)	CITY	STATE	ZIP CODE	DOB

NAME, RELATIONSHIP, ADDRESS & PHONE # OF EMERGENCY CONTACT	**PATIENT'S** HOME NUMBER: _____ CELL NUMBER: _____ EMAIL: _____

FAMILY HISTORY Diabetes: Heart Attack: High Cholesterol: High Blood Pressure:
Cancer: Stroke: Mental Health Dz: Other:

Who do you live with:	Pets: Indoor or outdoor

PERSONAL HISTORY: Please answer all questions. Comment on all positive answers below.

Have you had:				**Have you had:**			
INFECTIOUS DISEASES				**ENDOCRINE/METABOLIC**			
Measles	Y	N		Diabetes	Y	N	
German Measles	Y	N		Thyroid Problems	Y	N	
Mumps	Y	N		Other (Describe)	Y	N	
Chicken Pox (at what age)	Y	N		**MUSCULO-SKELETAL**			
Malaria	Y	N		Disease or Injury of Joints	Y	N	
Tuberculosis	Y	N		Arthritis	Y	N	
Mononucleosis	Y	N		"Trick Knee"/Shoulder, etc.	Y	N	
Hepatitis	Y	N		Back Problems	Y	N	
Sexually Transmitted Disease	Y	N		Other (Describe)	Y	N	
Other (Describe)	Y	N		**FEMALES ONLY**			
EYES/EARS/MOUTH				First day of last menstrual period			
Gum or Dental Problems	Y	N		Irregular Periods/Excess	Y	N	
Sinusitis	Y	N		Severe Cramps	Y	N	
Eye Problems	Y	N		Current Pregnancy	Y	N	
Ear Problems	Y	N		Other (Describe) G, P, A, L	Y	N	
Throat Problems	Y	N		**CARDIO-PULMONARY**			
IMMUNOLOGICAL				Shortness of Breath	Y	N	
Hay Fever (Seasonal allergies)	Y	N		Palpitations	Y	N	
Asthma	Y	N		Chest Pains/Pressure	Y	N	
Allergies To: Medicines	Y	N		Chronic Cough	Y	N	
Foods	Y	N		High Blood Pressure	Y	N	
GI AND GU DISORDERS				Rheumatic Fever	Y	N	
Frequent Nausea	Y	N		Heart Murmur	Y	N	
Frequent Diarrhea	Y	N		Recurrent Colds	Y	N	
Constipation	Y	N		Other (Describe)	Y	N	
Frequency of Urination	Y	N		**MISCELLANEOUS**			
Burning on Urination	Y	N		Tumors	Y	N	
Gall Bladder Problems	Y	N		Cancer	Y	N	
Other (Describe)	Y	N		Cysts	Y	N	
NEUROLOGICAL DISEASES				Other (Describe)	Y	N	
Frequent Headaches	Y	N		**PSYCHOLOGICAL**			
Dizziness or Vertigo	Y	N		Mental Health Disorder(s)	Y	N	
Head Injury/Unconsciousness	Y	N		Insomnia	Y	N	
Epilepsy/Convulsions	Y	N		Frequent Depression/Anxiety	Y	N	
Fainting	Y	N		Alcohol (ETOH)	Y	N	
Weakness	Y	N		Smoking	Y	N	
Paralysis	Y	N		Recreational Drugs (**cocaine/marijuana**)			
Other	Y	N		**Miscellaneous**			
BLOOD DISORDERS				Surgery	Y	N	
Clotting Disorder	Y	N		Hospitalizations overnight	Y	N	
Hemophilia	Y	N		Major Accidents	Y	N	
Leukemia	Y	N		Other (Describe)	Y	N	
Anemia (Type)	Y	N		**CURRENT MEDICATIONS (List)**	Y	N	

Reviewed by: _____ Date: _____

A. Has your physical activity been restricted during the past five years? **YES** _____ **NO** _____ (Give reasons)_____
_____

B. Have you had difficulty with school studies or teachers? **YES** _____ **NO** _____ (Describe) _____
_____

C. Have you received treatment or counseling for a nervous condition, personality or character disorder, emotional problems or chemical/alcohol dependence? **YES** _____ **NO** _____ (Give details)
_____

D Have you had any illness or injury or been hospitalized other than that already noted? **YES** _____ **NO** _____ (Give details) _____
_____

E. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years? (Other than routine checkups?) **YES** _____ **NO** _____ (Give Details) _____

F. Have you been rejected or discharged from military service or employment because of physical, emotional, or other reasons? **YES** _____ **NO** _____ (If so, give reasons) _____

G. Do you have any learning disabilities for which you may require assistance? **YES** _____ **NO** _____ (Describe) _____
_____

I certify this personal history information to be correct: _____
Student (CLIENT) Signature **Date**

TO THE EXAMINING PHYSICIAN/ADVANCED PRACTICE NURSE/PHYSICIAN ASSISTANT: Please review the student's history and complete the physical form. Please comment on positive answers. This information is for the use of the Health Careers Programs and will not be released without student consent. *Physician/Advanced Practice Nurse/Physician Assistant must be licensed in the United States.*

_____
LAST NAME (Please Print) **FIRST NAME** **MIDDLE NAME** **GENDER** **AGE**

Height _____ Temp_____ B/P _____ **Corrected/Non-Corrected Vision**: R _____ L _____ Both _____

Weight: _____ Pulse _____ Resp. _____ O2 Sat on RA_____% Corrective Lenses: **Y/N** Why_____ How Long_____

_____
IMMUNIZATIONS REQUIRED BY EPCC: **DATES** **(Immunization Record/Copy must be attached)**

Varicella: 1st_____ 2nd_____ **OR** Age of actual Illness _____ **OR** BLOOD TITER _____
Polio (3 doses up to age 19) _____
Measles, Mumps, Rubella: 1st_____ 2nd _____ OR BLOOD TITER
Tdap (Tetanus, diphtheria, pertussis) or Td (dose in past 10 years) _____
Tuberculin Skin Test (Chest X-ray, if indicated) _____ NEGATIVE _____ POSITIVE _____
Hepatitis B: 1st _____ 2nd _____ 3rd _____ **OR** BLOOD TITER _____
Other:

Physical Assessment	**Normal**	**Abnormal**	**Not Examined**	**Comments**
1. Head, Ears, Nose, or Throat				
2. Respiratory				
3. Cardiovascular/Blood				
4. Gastrointestinal				
5. Hernia				
6. Eyes				
7. Genitourinary (Males only)				
8. Musculoskeletal				
9. Metabolic/Endocrine				
10. Neurological				
11. Skin				
12. Psychiatric/Emotional				

Recommendations for physical activity (including lifting, carrying, or standing) **Unlimited/ Limited** _____

Recommendations for accommodations for any learning disabilities, physical disabilities, or emotional disabilities **Yes/No**

(Explain) _____

General Comments:_____

_____
EXAMINER'S SIGNATURE **EXAMINER'S NAME and TITLE (typed or printed)**

_____ _____ _____ _____
ADDRESS **PHONE** **FAX** **DATE**