El Centro College
Health Services Program
Immunization and Physical Exam Requirements

The immunization requirements on this form are REQUIRED of all individuals applying to El Centro College. You MUST submit your health documentation, ***in PDF format***, for each immunization requirement listed on this form.

Below is a listing of facilities we can accept immunization documentation/records from:

We cannot accept elementary and/or high school immunizations printed on transcripts and/or report cards.

1. Childhood immunizations on official health immunization forms and/or "booklets" that have been signed and dated by a physician.
2. State Health Departments (**example**: Clinics)
3. Hospitals
4. Physician's Office (*Will not accept notes from Doctor's or anyone in his office verifying immunizations were given. If from a physician's office immunizations must be on a printout indicating dates given along with office address information.*)
5. College/University Health Centers (*Will not accept immunizations printed on a transcript*.)
6. Drug/Grocery Stores (**example**: Walgreens, CVS, Albertsons or Walmart)
7. Urgent Care Centers (**example**: CareNow)
8. Titers (This is a blood test applicants receive to verify immunity if they cannot locate immunizations they have received.)
9. Military records clearly indicating when immunizations and/or titers were given and/or completed.
10. We cannot accept payment receipts as proof of immunizations received.
11. You may submit your physical exam on the form included or you may submit your physical with your facility form. The physical exam is good for one (1) year.
12. American Heart Association is the only approved CPR courses (Must be American Heart Association, BLS, face to face or hybrid course is acceptable, no online only course will be accepted)

Immunization Requirements

1. **MMR: (2 doses required to apply):**
   - **a.** Documentation of two (2) FULL MMR shots, i.e. 2 Measles (Rubeola), 2 Mumps, and 2 Rubella **OR**
   - **b.** **Positive** Immunoglobulin G (**IgG**) antibody titers to Measles (Rubeola), Mumps and Rubella
   - **c.** If **negative** then the applicant will need to show proof of booster **after** receiving the negative titer and evidence of previous vaccine

2. **Varicella: (2 doses required to apply):**
   - **a.** Two (2) vaccines administered at least one month apart **OR**
   - **b.** **Positive** Varicella Zoster IgG titer for Varicella (chicken pox)
   - **c.** If **negative** then the applicant will need to show proof of booster **after** receiving the negative titer and evidence of previous vaccine
   - **d.** History of the disease is **NOT** acceptable.

3. **Tetanus, Diphtheria, Pertussis (TDAP): (Required to apply)**
   - **a.** Administered within last 10 years.

4. **Hepatitis A: Dental Hygiene, Paramedic and Nursing**
   - **a.** One (1) Hepatitis A shot for admission
   - **b.** Receive second (2) dose prior to beginning of the semester (please see information packets for due date)
   - **c.** **Positive** Hepatitis A Total Antibody titer
   - **d.** If **negative** then the applicant will need to show proof of booster **after** receiving the negative titer and evidence of previous vaccine
   - **e.** Will accept Twinrix series

5. **Hepatitis B:**
   - **a.** Three (3) Hepatitis B shots **OR**
   - **b.** **Positive** Hepatitis B Surface Antibody titer
   - **c.** If **negative** then the applicant will need to show proof of booster **after** receiving the negative titer and evidence of previous vaccine
   - **d.** Will accept Twinrix series

   OR

   - **e.** Two (2) Hepatitis B CPG shots at least 4 weeks apart **OR**
   - **f.** **Positive** Hepatitis B Surface Antibody titer

6. **Annual TB test(PPD):**
   - **a.** TB skin test, QuantiFeron Gold Test (blood test), T-Spot or TST is accepted

   If the results are positive (+) then documentation of a chest x-ray is required and must be negative for active disease.
   If the applicant has tested positive in the past documentation must be submitted of the positive screen. In the event that an applicant has received the BCG injection documentation of that injection and a negative x-ray report must be submitted together.

7. **Annual Influenza Vaccine:** El Centro College **will notify** students when current seasonal Influenza vaccines are to be obtained. *Influenza documentation must include date administered, vaccine administered, injection site, dose, route, manufacturer, Lot Number and expiration date in order to be accepted.*

Flu Vaccine Form
You must use this form for documentation of your flu vaccine

Applicant Full Name: _____ Date of Birth: ____/____/_____

Email Address: _____ DCCCD ID #: _____

Date administered	
Name of vaccine administered	
Injection site	
Dose	
Route	
Manufacturer	
Lot Number	
Expiration date	

Signature of health professional administering the vaccine is required for the form to be accepted

_____ Date: _____
Signature

Printed name:_____

Phone Number: (____)_____

Address: _____

You may use this form or one provided by your health care provider (must be completed by your physician or nurse practitioner).

Applicant Full Name: _____ Date of Birth: ____/____/_____

Email Address: _____ DCCCD 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 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 to turn and/or move heavy objects? If "no," please describe: Yes____ No____

Is the applicant able to see and hear adequately to practice a health care profession? If "no," please explain: Yes____ No____

Is the applicant free of any pathological conditions either physical or mental that would interfere with the practice of a health profession? If "no," please describe: Yes____ No ____

Physician or Nurse Practitioner Signature is required for Physical Examination form to be accepted

_____ Date: _____

Signature of Physician or Nurse Practitioner

Printed name of Physician or Nurse Practitioner: _____

Phone Number: (____)_____

Address of Physician or Nurse Practitioner: _____