School of Health Sciences
DALLAS COLLEGE

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.

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

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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 to turn and/or move heavy objects? If "no," please describe: Yes ____ No ____

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 With the practice of a health care profession? If "no," please describe: Yes ____ No ____

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: _____

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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.:

_____
_____
_____