**Oxnard College Student Health Center**

**EMT Office Visits**

1. **First Appointment- RN (45 min)**
* PPD #1 and medical record review. Bring any current physical exam (last 12 months). Also bring any blood titers and/or immunizations.
* EMT Blood work **(titers: Hepatitis B required even with proof of past immunization)** Varicella, Mumps, Rubella, Rubeola as needed.
* Drug Screen will be ordered and you will be sent out to Quest to complete by 3rd Visit.
1. **Second Appointment- Deanna McFadden, DNP/ Dr.Nugent (30 min)**
* PPD #1 Read (Must be read within 48 to 72hrs from date and time applied)
* Physical Exam
1. **Third Appointment- RN (15 min)**
* PPD #2 (has to be placed at least 7 and no longer than 21 days from PPD #1)
* If required, the following vaccines will be administered at this appointment. (Tdap, Hepatitis B, Flu)
1. **Fourth Appointment- RN (30 min)**
* PPD #2 Read (Must be read within 48 to 72hrs from date and time applied)
* If required, the following vaccines will be administered at this appointment: MMR, Varicella
* You will be provided a summary of charges applicable to you. These will be posted to your VCCCD account and payment must be submitted at OC Student Business Office or on your VCCCD portal electronically.

**Office Schedule: Appointments with Karen Paxton, RN**: Monday 9am to 3pm

 Tuesday 9am to 4pm

 Friday 9am to 11pm

**Deanna McFadden, DNP, RN:** Monday and Tuesday 9am to 12pm

 Wednesday and Thursday 1pm to 4pm

**Dr. Nugent:** Tuesday and Wednesday 9am to 2pm

**\*Please note $10 no-show fee will be charged. Please call to reschedule or cancel 24 hours prior to appointment date.\***

**Oxnard College Student Health Center Fees**

|  |  |
| --- | --- |
| Hepatitis B titer | $8.00 |
| Varicella titer | $5.00 |
| Mumps titer | $13.00 |
| Rubella titer | $4.00 |
| Rubeola titer | $6.00 |
| PPD skin test (2step-$6 each) | $12.00  |
| Tdap vaccine | $35.00 |
| Hepatitis vaccine | $35.00 |
| Flu vaccineVaricella vaccine | $20.00$107.00 |
| MMR vaccine | $60.00 |
| Urine Drug Screen | $12.00 |
| Physical Exam | $20.00 |

Quantiferon Gold TB $57.00

**Important information about your EMT requirements:**

* **Please note that you may not need of all the above listed services, we will evaluate what services are needed and the total fee will be determined accordingly.**
* **If you have any prior immunization records, please bring them to your first appointment. Missing vaccinations will be administered at the third and fourth appointment.**
* **IF you decide to have your physical with your Primary Care Provider (PCP) please make sure the following items and forms (pages 5 & 6) are *completed* and *signed off* by your provider.**
* **If your PCP does *not* order the URINE DRUG SCREEN TEST you may call our office to request the lab requisition for Quest Diagnostics Lab and instructions will be provided over the phone and via email.**
* **If you choose to use your primary care providers, you *must* schedule an appointment at the Oxnard College Student Health Center for a “paper work review” before your instructor will accept your health clearance for class.**

**Since the Health Center does NOT bill insurance, please check with your medical insurance carrier to see if they cover the required vaccinations, blood tests, and urine drug screen.**

**\*INSTRUCTIONS for PRIMARY CARE PROVIDER**

**1. TB Clearance**

**\*2-step PPD OR Quantiferon Gold TB blood test (students choosing clinical site at Los Robles Hospital MUST have Quantiferon done in place of PPD skin test).**

**(PPD#2 must be placed at least 7 days and no longer than 21 days after placement PPD #1, *the results are invalid if a live virus vaccine is placed prior to read date, such as MMR, varicella, or live virus flu)***

**2.Proof of Immunity**

**Hepatitis B-documentation of 3 doses if available AND Hepatitis B antibody titer**

**Varicella-documentation of 2 doses OR varicella titer**

**Rubeola-documentation of 2 doses OR rubeola titer**

**Mumps-documentation of 2 doses OR mumps titer**

**Rubella-documentation one 1 dose OR rubella titer**

**\*MANDATORY HEP B Antibody TITER with/without documented 3 dose series. Send**

 **copy of titers with student.**

**\*Boosters required if Negative titer for Hep B, Varicella, MMR**

**3.REQUIRED VACCINES**

**Tdap (current within 10 yrs.)**

**Flu (current Flu season) Proof of vaccination required/ Lot #**

**4. Urine Drug Screen-attach copy of results**

**5. Physical Exam by licensed PCP**

**Physical Examination**

**Laboratory and Immunization Report**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Student ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First Initial

Age: \_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



|  |
| --- |
| **Vision** |
| **OS: /**  |
| **OD: /** |
| **OU: /** |
| **Ishihara** |
| **Normal** □ |
| **Abnormal** □ |

**PHYSICAL**

Ht. \_\_\_\_\_\_\_\_\_\_ Wt. \_\_\_\_\_\_\_\_\_\_ BP \_\_\_\_\_\_\_\_\_\_ P \_\_\_\_\_\_\_\_\_\_ R \_\_\_\_\_\_\_\_\_\_ **\*Must Complete Vision Screen**

**PHYSICAL EXAM NORMAL ABNORMAL COMMENTS**

|  |  |  |  |
| --- | --- | --- | --- |
| Appearance |  |  |  |
| Skin |  |  |  |
| HEENT |  |  |  |
| Lymph Nodes |  |  |  |
| Thyroid |  |  |  |
| Lungs |  |  |  |
| Heart |  |  |  |
| Abdomen |  |  |  |
| Genitourinary |  |  |  |
| Musculoskeletal |  |  |  |
| Extremities |  |  |  |
| Neurological |  |  |  |
| Vision Screening |  |  |  |
| Hearing |  |  |  |
| Mental Status |  |  |  |
|  |  |  |  |

 **YES** **NO** **COMMENTS**

|  |  |  |  |
| --- | --- | --- | --- |
| Any restrictions on physical activity? |  |  |  |
| Any recommendations for medical care? |  |  |  |

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

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

**Signature** of licensed health care professional **Medical Facility**  Street Address

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

**Print name** licensed health care professional City State Zip Code

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

**License (Type & Number)** Telephone Number

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_ **Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NOTICE TO HEALTH CARE PROVIDER:**

**This form must be completed. Hep B titer is required regardless of immunization record. Please provide a copy of ALL blood work and Urine Drug Screen Results, along with paper proof of Flu vaccine (required by hospitals for completion of program clinical requirement.)**

**Proof of Immunity**

**Hepatitis B-documentation of 3 doses if available AND Hepatitis B antibody titer**

**Varicella-documentation of 2 doses OR varicella titer**

**Rubeola-documentation of 2 doses OR rubeola titer**

**Mumps-documentation of 2 doses OR mumps titer**

**Rubella-documentation one 1 dose OR rubella titer**

**REQUIRED IMMUNIZATIONS:**

**TDAP Date: \_\_\_\_\_\_\_\_\_ Flu Vaccine (current Flu Season & Lot #) Date:\_\_\_\_\_\_\_\_\_\_**

**MMR#1 Date: \_\_\_\_\_\_\_\_\_ MMR #2 Date: \_\_\_\_\_\_\_\_\_\_**

**Varicella #1 Date: \_\_\_\_\_\_\_\_\_ Varicella #2 Date: \_\_\_\_\_\_\_\_\_\_**

**Hepatitis B #1 Date: \_\_\_\_\_\_\_\_\_\_ Hepatitis B #2 Date: \_\_\_\_\_\_\_\_\_\_ Hepatitis #3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Booster (if needed)\_\_\_\_\_\_\_\_\_ then HEPATITIS B TITER 1-2 MONTHS FOLLOWING BOOSTER\_\_\_\_\_\_\_\_\_**

**CIRCLE RESULTS :**

**LAB TEST DATE RESULTS RESULTS COMMENTS/ Booster if needed**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PPD #1** |  |  |   |  |
| **PPD #2** |  |  |   |  |
| **HB SURF AB titer MANDATORY** |  | Positive |  Negative |  |
| **VARICELLA TITER** |  | Immune |  Not Immune |  |
| **MUMPS TITER** |  | Immune |  Not Immune |  |
| **RUBELLA TITER** |  | Immune |  Not Immune |  |
| **RUBEOLA TITER** |  | Immune |  Not Immune |  |
|  |  |  |  |  |
| **UA DRUG SCREEN** |  | Positive |  Negative |  |
| **CHEST X-RAY FOR TB CLEARANCE IF POS. TB TEST****QUANTIFERON TB GOLD**  |  | PositivePositive |  NegativeNegative |  |

**LICENSED HEALTH CARE PROFESSIONAL’S CERTIFICATION**

**After careful review of the history, the physical finding and the result of the laboratory tests, I certify that this patient:**

 **1. Has no communicable disease;**

 **2. Has all required immunizations and has proof of immunity through appropriate titer . levels;**

**3. Has not physical limitation, which impedes the unrestricted practice of direct patient care in a clinical**

 **setting.**

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

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

**Signature** of licensed health care professional **Medical Facility**  Street Address

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

**Print name** licensed health care professional City State Zip Code

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

**License (Type & Number)** Telephone Number