El Centro College Health Occupations
Immunization and Physical Exam Requirements

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

Email Address: _____ DCCCD ID #: _____

All applicants **must** complete these forms and return them to Sentry MD with their health records.

This form is only valid for **ONE** (1) filing period.

If you chose to reapply or apply for a different El Centro College' Allied Health and/or Nursing program then you **MUST resubmit** this questionnaire form, ***pages 1 & 2***, to Sentry MD notifying them of your intent.
Sentry MD will then re-evaluate your health records that are on file and notify you, *via email*, of your status.

Please make sure to allow **7 to 10** business days for Sentry MD to review your records on file and let you know what additional items you need, *if any*, for a complete application.

A.D.N. Nursing applicants only!				
Circle *which nursing location(s) you're applying for.*	ECC	NLC	HCA	MHS

Which Allied Health and/or Nursing program are you applying for? (Check (✓) all that apply)

Please indicate what year you're applying for: 20_____

Program	Filing Period	Selection (✓)
Associate Degree Nursing	**Spring**: May 1 – July 15	
	Fall: November 1 – January 31	
Cardiac Sonography	September 1 – December 31	
Dental Hygiene	April 1 – May 31	
Diagnostic Medical Sonography	September 1 – December 31	
Invasive Cardiovascular Technology	September 1 – March 15	
LVN to RN Advance Placement "Bridge"	**Spring**: May 1 – July 15	
	Fall: November 1 – January 31	
Magnetic Resonance Imaging (MRI)	January 1 – March 15	
Medical Assisting	**Spring**: August 1 – October 31	
	Fall: January 1 – May 31	
Medical Laboratory Technology	January 1 – March 15	
Perioperative Nurse Internship	***Fall Only:*** May 1 – June 15	
Radiologic Sciences	January 1 – May 31	
Respiratory Care	January 1 – May 17	

Programs continued on next page…

El Centro College Health Occupations
Immunization and Physical Exam Requirements

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

Email Address: _____ DCCCD ID #: _____

Please indicate what year you're applying for: 20_____

Program	Filing Period	Selection (✓)
Surgical Technologist	January 1 – May 31	
Vocational Nursing	January 1 – May 31	

El Centro Program:	Filing Dates	"City of" Location	Selection (✓)
Paramedic – Civilian	***Spring***: September 1 – November 15		
	Summer: March 1 – May 15		
Paramedic - Department	***Spring***: September 1 – November 15		
	Summer: March 1 – May 15		

Please answer **ALL** the following questions.

1) Have you **applied** to an El Centro Allied Health and/or Nursing program previously?	Yes	No
2) If you answered **yes** to question **#1** when and what program?		
3) If **reapplying,** did you **resubmit** the questionnaire form notifying Sentry MD of your intent to reapply?	Yes	No
4) Have you ever been **accepted** into an El Centro Allied Health and/or Nursing program?	Yes	No
5) If you answered **yes** to **#4**, when and what program?		
6) Have you paid the Sentry MD application fee of $15 before?	Yes	No
7) If you answered **yes** to **#6** when?		
8) Have you ever submitted health records to Sentry MD?	Yes	No
9) If you answered **yes** to **#8** when?		
10) Are you currently in an El Centro Allied Health and/or Nursing program?	Yes	No
11) If you answered yes to #**10** which program are you currently in?		

_____ By initialing this form I understand that it is my responsibility, *as an applicant*, to answer **all** of the above questions to the best of my ability.
Initial

_____ By initialing this form I understand that it is my responsibility, *as an applicant*, **to complete a new questionnaire form and email** it to Sentry MD notifying them of my intent to **apply** or **reapply** to **any** El Centro College Allied Health and/or Nursing program(s).
Initial

_____ _____
(Print Name) (Date)

El Centro College Health Occupations
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 in order for Sentry MD to process your immunizations and physical exam documentation. If your health documentation is not received for all of the requirements listed below you will not be reviewed by Sentry MD and El Centro College.

Submit all of your documentation to Sentry MD by emailing as **ONE** pdf attachment to ElCentro@SentryMD.com. Individual attachments of documents in an email will not be processed. Documents received in any other format than one pdf attachment will not be processed. **Processing time could take up to 14 business days**. Multiple submissions of your documents will result in a delay of processing time.

PART I-To be completed by the applicant

Additional documents to submit to Sentry MD with Immunization Records and Physical Exam:

1) Completed Questionnaire Form (Questionnaire form is only good for ONE (1) filing period.)

2) Healthcare Level Provider or Basic Life Support (BLS) CPR Certification:

   a. Students must carry active BLS CPR Certification
   b. Online courses are not accepted
   c. Please submit a front and back copy of your BLS CPR card.
   d. The back of your CPR card must be signed by the applicant.

3) Include a copy of your application payment receipt. (Application fee is good for **one (1) year** only.)

4) Sentry MD REQUIRED payments: Students will be required to make the following payments.

   a. $15 application fee. Due at the time of application and is **ONLY** good for one (1) year.
   b. $20 yearly fee. This is **REQUIRED** only if you're **accepted** into an El Centro College' Allied Health or Nursing program.

PART II - 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. (**Remember**: we CANNOT accept immunizations from elementary and/or high school transcripts and/or report cards.)
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've received.)

   If titers are negative then applicants MUST provide proof of immunizations received AFTER the negative titers were reported. If titer(s) are negative then ALL series immunizations must be completed for that particular immunization. If titers give a number result then a range chart of acceptable values MUST be indicated on the report to provide an explanation of results reported.
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.

Applicants may also submit titers, *blood drawn to check for antibodies in your system from prior immunization or infection*, as proof of immunization. **Please note,** if titers are negative then the applicant will need to show proof of full vaccination series completed **after** receiving the negative titer. The titers for MMR and Varicella must be Immunoglobulin G (**IgG**). For Hepatitis B the titer must be *Hepatitis B Surface Antibody* and for Hepatitis A the titer must be *Hepatitis A Total Antibody*. Titer reports **must** include range or reference value if a number result is given. We **do not** accept TDAP titers. You must show proof of a full TDAP shot ***not*** TD.

Notice!!!

Effective **Spring 2017 and beyond ALL** nursing program applicants; Associates, LVN-RN, and Vocational; will be required to have **ALL** Hepatitis A and B series shots *completed by the application deadline date* in order to apply to any and all nursing program for El Centro College.

PART III - Immunization Requirements

Please refer to **PART II** for facilities we can accept immunization documentation/records from.

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 full vaccination series completed **after** receiving the negative titer

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 full vaccination series completed **after** receiving the negative titer.
   - **d.** History of the disease is **NOT** acceptable.

3. **Tetanus, Diphtheria, Pertussis (TDAP): (Required to apply)**
   - **a.** Administered within last 10 years.
   - **b.** We **do not** accept Tetanus booster (TD).
   - **c.** We **do not** accept TDAP titers.

4. **Hepatitis A:**
   - **a.** Two (2) Hepatitis A shots (0, 6 months) **OR**
   - **b.** **Positive** Hepatitis A Total Antibody titer
   - **c.** If **negative** then the applicant will need to show proof of full vaccination series completed **after** receiving the negative titer.
   - **d.** Will accept Twinrix series (0, 1, 6 months)

5. **Hepatitis B:**
   - **a.** Three (3) Hepatitis B shots (0, 1, 6 months) **OR**
   - **b.** **Positive** Hepatitis B Surface Antibody titer
   - **c.** If **negative** then the applicant will need to show proof of full vaccination series completed **after** receiving the negative titer.
   - **d.** Will accept Twinrix series (0, 1, 6 months)

Immunizations continued on next page…..

6. **Annual TB test(PPD):**
   - **a.** Tuberculin Skin Test (TST)
     - i. Must include millimeters (mm) of induration and (pos (+) or neg (-)) indication. **OR**
   - **b.** TB QuantiFeron Gold Test (blood test) **OR**
   - **c.** T-SPOT (blood test)

   If the results of either the TST, QuantiFeron Gold or T-SPOT test is positive (+) then documentation of a chest x-ray is required and must be negative for active disease. **BOTH** the positive TST, QuantiFeron Gold or T-SPOT test and the negative x-ray report **must be** submitted together.

   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 student when current seasonal Influenza vaccines are to be obtained. *Influenza documentation must include date administered, vaccine administered, injection site, dose, route, mfg, Lot Number and expiration date in order to be accepted.*

NEW!!!! Student Notifications (**Effective Now**)

Students will **no longer** receive notification emails during the application filing periods indicating "Compliant" or "Non-complaint" to whichever program you've applied too. You will **now** receive notification emails, during the application filing periods, if you're "Complete" or "Not complete" with your health records. If you are not complete then the notification email will inform you of what you're missing.

Example of a "**Complete**" status email notification:

Hi (student name here),

We have received your health records and they have finished processing. Please refer to your status below.

Status: Health records are complete

"It is the applicant/students responsibility to make sure that ALL of their health records including TB skin test, physical exams and Healthcare Provider CPR are up-to-date at the end of the application filing period and **throughout the program**"

Example of a "**Not complete**" status email notification:

Hi (student name here),

We have received your health records and they have finished processing. Please refer to your status below.

Status: Health records are not complete

Missing:
CPR – expires (date)
TB – Expires (date)

Please submit and/or update the above item(s) and send the additional document(s) to ElCentro@SentryMD.com as one pdf so that we may complete the review of your health records. ***You do not need to resubmit the documents you have already submitted just the ones you need to update.*** *Please let me know if you have any questions!*

*"It is the applicant/students responsibility to make sure that ALL of their health records including TB skin test, physical exams and Healthcare Provider CPR are up-to-date at the end of the application filing period and **throughout the program**"*

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

Email Address: _____ DCCCD ID #: _____

Part IV: Applicants: Be sure to sign the immunization release statement below

I have reviewed the requirements on this form and have submitted my health documentation for review and agree to release the information provided on the El Centro College Health Occupations Immunization and Physical Exam Forms to authorized members of the Institute staff and authorizes staff of cooperating agencies, as may be required.

Print applicant name: _____ Date of Birth: _____

Applicant Signature: _____ Date: _____

El Centro College works with Sentry MD, a confidential health information service. Sentry MD maintains and processes all student immunization records and monitors compliance with state law requirements. The information may be provided to authorized members of the Institute staff and authorized staff of cooperating agencies as may be required.

Submit forms to Sentry MD by emailing as **ONE pdf attachment** to ElCentro@SentryMD.com. **Individual attachments in an email will not be accepted. Image or embedded files will not be accepted.**

PART V - Health Questionnaire (To be completed by the applicant)

Do you have any physical limitations which would affect your ability to lift, turn, or transfer patients? Yes_____ No_____

Do you have any limitations in use of your senses, such as sight or hearing, which would limit your ability to practice a health profession? Yes_____ No_____

Do you have any other condition which might interfere with your ability to practice a health profession? Yes_____ No_____

For questions please email Sentry MD at ElCentro@SentryMD.com or Kanora Jackson at k.jackson@dcccd.edu.

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

Email Address: _____ DCCCD ID #: _____

PART VI - Physical Examination (to be completed by physician or nurse practitioner).

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: _____

Place Provider Stamp Here