WCTC Self-Pay Student Physicals 2013 – 2014

ProHealth Works is pleased to provide these physical examinations at our three clinic locations:

ProHealth Works – Waukesha
The Seeger Medical Office Building
20611 Watertown Road Suite J
Waukesha, WI 53186
Hours Monday – Friday: 8 a.m. – 5 p.m.

ProHealth Works – Oconomowoc
Oconomowoc Physician Center/
Parking Lot #2 / Door #2
1185 Corporate Center Drive
Oconomowoc, WI 53066
Hours Monday – Friday: 8 a.m. – 4:30 p.m.

To schedule an exam or testing at any of our three locations call 262-928-5900.

**Appointments are required. Cash and all major credit cards (Mastercard, Visa, Discover and American Express) accepted. Checks not accepted.**

Examination Components & Pricing:

- Student Physical Examination $39
- DOT Physical Examination $52
- Chest X-Ray $70
- Flu Shot $27
- TB Skin Testing $12
- Quantiferon Gold TB Testing $78
- Tetanus-TDAP Vaccine $40
- MMR Vaccine $59
- Hepatitis B Vaccination (series of 3) $50 each
- Hepatitis B Titer $30
- Varicella Vaccine $75
- Varicella Titer $90
- Venipuncture $19
- Rubeola Titer $40
- Rubella Titer $40
- Mumps Titer $30
- Rapid 10 Panel Drug Test $50
- DOT Drug Test $47
- PFT $35
- Audiogram $26

** Please bring all documentation of your previous Immunizations & Titers**
# Nursing Student Health Requirements

<table>
<thead>
<tr>
<th>Student Last Name</th>
<th>First Name</th>
<th>M.I.</th>
<th>DOB</th>
<th>WCTC ID#</th>
</tr>
</thead>
</table>

*A qualified health care provider (QHCP) or designee MUST INITIAL and FILL IN APPROPRIATE INFORMATION IN EACH CATEGORY and SIGN at the BOTTOM OF THE PAGE to indicate each health care requirement is satisfied.*

## Physical Exam
- **Physical examination** obtained within **one year prior** to the start of clinical experiences is **required**. The examination must be given by a qualified health care provider (QHCP) to ensure the student can perform all essential functions expected of a health care profession student.

  - QHCP Signature ___________________________ Date ____________________ *meets definition above

  - An OB/GYN exam does not meet this requirement.

## Tuberculin (TB) Skin Test
Fill out section that is pertinent to you.

- **If no TB test has been completed within the last 12 months, a two-step is required (Second test (step) occurs 7-21 days after first test)**

  1. Date of 1st Skin test _______ Results______ Date______ QHCP Initials______
  2. Date of 2nd Skin test_______ Results______ Date______ QHCP Initials______

- **Written proof of 2 consecutive annual negative TB skin test results within the last 24 months.**

  - Date Year 1 skin test ___________ Results______ Date______ QHCP Initials______
  - Date Year 2 skin test___________ Results______ Date______ QHCP Initials______
  - Date Year 3 skin test___________ Results______ Date______ QHCP Initials______

- **OR**
  - Students with a history of positive reactions to TB MUST have a Quantiferon blood test. If positive, student will need to have an annual symptom review by a QHCP, which may require a chest x-ray.

  - **Quantiferon** administered instead of a TB skin test

  - Date of Quantiferon blood test_______ Results______ QHCP Initials______
  - Positive Reactor Yes_______No_______ Results______ QHCP Initials______
  - Quantiferon instead of TB Yes_______No_______ Results______ QHCP Initials______
  - Annual Symptom Review/Updates Date_______Results______ QHCP Initials______
  - Annual Symptom Review/Updates Date_______Results______ QHCP Initials______

(Continue on back)
### IMMUNIZATIONS/VACCINES

<table>
<thead>
<tr>
<th>Vaccination Type</th>
<th>Requirements</th>
<th>Date of last booster/immunization</th>
<th>QHCP Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus/Diptheria / (Tdap) Tetanus-Diptheria-Pertussis (Tdap is a one time booster)</td>
<td>• Required to be done every 10 years.</td>
<td>Date of last booster/immunization</td>
<td>QHCP Initials</td>
</tr>
<tr>
<td>Measles/Mumps/Rubella (MMR)</td>
<td>• Immunity must be proven by either:</td>
<td>Written proof: Date 1__________Date 2_______</td>
<td>QHCP Initials</td>
</tr>
<tr>
<td></td>
<td>• Written Proof of two MMR vaccines.</td>
<td>Rubella titer: Date__________Results_______</td>
<td>QHCP Initials</td>
</tr>
<tr>
<td></td>
<td>• Positive titers</td>
<td>Rubeola titer: Date__________Results_______</td>
<td>QHCP Initials</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>Mumps titer: Date__________Results_______</td>
<td>QHCP Initials</td>
</tr>
<tr>
<td></td>
<td>• Immunity must be proven by either:</td>
<td>Positive Varicella titer: Date_______Results_______</td>
<td>QHCP Initials</td>
</tr>
<tr>
<td></td>
<td>• Written proof of 2 varicella vaccines at least 30 days apart as an adult or 1 dose if under age 13</td>
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</tr>
<tr>
<td></td>
<td>• Positive Varicella titer</td>
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</tr>
<tr>
<td>Varicella Immunization</td>
<td>• Hepatitis B vaccination series must be completed within 4-6 months.</td>
<td>Date 1__________Date 2__________Date 3_________</td>
<td>QHCP Initials</td>
</tr>
<tr>
<td></td>
<td>• Hepatitis B vaccination series must be initiated prior to the start date of student's first clinical course and completed within 6 months of enrollment in that course. Six weeks after the third dose a Hepatitis titer must be drawn to confirm immunity.</td>
<td>Hepatitis B titer Date__________Results________</td>
<td>QHCP Initials</td>
</tr>
<tr>
<td></td>
<td>• Hepatitis B titer</td>
<td>Waiver-A declination form must be filled out by the student in the presence of the Nursing Program Coordinator and kept on file in the Nursing Office.</td>
<td></td>
</tr>
<tr>
<td>Annual Flu Vaccine</td>
<td>Annual Flu Vaccine Reviewer/Date</td>
<td>Annual Flu Vaccine Reviewer/Date</td>
<td></td>
</tr>
<tr>
<td>HCP CPR</td>
<td>HCP CPR Reviewer/Date</td>
<td>HCP CPR Reviewer/Date</td>
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</tr>
<tr>
<td>Safety quiz</td>
<td>Safety quiz Initials/Date</td>
<td>Safety quiz Initials/Date</td>
<td></td>
</tr>
<tr>
<td>Nursing Reviewer Date</td>
<td>Student Validation and Signature</td>
<td>Student Signature/Date</td>
<td></td>
</tr>
</tbody>
</table>

I understand that the information provided on this form may be shared with WCTC associated clinical field sites and consent to its release. I understand that WCTC can't guarantee allergen-free clinical/field sites and if I have an allergy or sensitivity to a particular allergen, it is my responsibility to mitigate potential reactions through appropriate means. I further affirm that the information contained within this form is true & accurate.

**Student Signature/Date**