INDIAN RIVER STATE COLLEGE

Health Science Division

PHYSICAL EXAMINATION DIRECTIONS

IMMUNIZATIONS MAY TAKE 30 DAYS TO COMPLETE, SO MAKE AN APPOINTMENT AS SOON AS POSSIBLE.

FRONT OF FORM

1. Student to complete the top portion of the form. Check your health science program (right hand corner).
2. Physician or nurse practitioner to complete the bottom portion of the form, **sign, and date, including the complete address and phone number of the facility. Form will not be accepted without this information completed. (Cannot be a Chiropractor.)**

BACK OF FORM

I. **Tuberculin Test: Follow your healthcare provider's procedure for Tuberculin Skin Testing Method.** If Tuberculin Skin Test or Quantiferon Gold Test is positive, have chest X-ray taken or complete the symptom-free checklist if you have had a positive chest x-ray in the past. This test is valid for one year from the time of reading, and must be valid through the end of each semester. (If the TB expires during the semester, it must be updated prior to registering for the semester.)

II. **MMR:** (Measles, Mumps, Rubella Vaccine) – (a) Proof of two vaccines (physician requires that there be one month between vaccines), or (b) proof of immunizations by titer, or (c) exempt from vaccine if born before 1/1/57. If born after 1/1/57, must have proof of two (2) MMR vaccines after age one (1).

III. **Tetanus/Diphtheria/Pertussis:** Proof of immunization within the last seven years. (If the Tetanus expires during the semester, it must be updated prior to registering for the semester.)

IV. **Hepatitis Vaccination:** (a) Proof of **either** two Heplisav B or three Hepatitis B immunizations **and** positive surface antibody test 1-2 months after all doses, or (b) Positive Hepatitis B Titer. If you do not have (a) or (b) sign to decline immunization at this time.

V. **Varicella Status:** (a) Known history of chickenpox with positive Varicella Titer, or (b) 2 doses of the Varicella Vaccine.

VI. **Annual Influenza (Flu) Vaccine**: Vaccine must be done every year.

VII. **Physician or Nurse Practitioner must initial each section where data is entered then sign and date at the bottom.**

All health information that is not documented on health forms must have:

1. Letterhead from institution or physician or nurse practitioner.
2. Signature of physician or nurse practitioner.
3. Date immunization or update was given.

INDIAN RIVER STATE COLLEGE
HEALTH SCIENCE DIVISION

This record becomes College property. Students must make personal copies prior to submission; copies will not be provided once submitted.
Note: This information may be shared with clinical agencies.

Physical Examination

Health Science Program: Select One

- ❒ Dental Hygiene
- ❒ EMT/Paramedic
- ❒ Medical Assisting
- ❒ Medical Lab Technology
- ❒ Pharmacy Technician
- ❒ Phlebotomy
- ❒ Phy. Therapy Asst. (PTA)
- ❒ Radiography
- ❒ Respiratory Care
- ❒ Surgical Technology

TO BE COMPLETED BY STUDENT BEFORE EXAMINATION

Last Name	First	Middle	(Area Code) Home Phone	Birth Date

Street Address	Apt.	City	State	Zip Code

Emergency Contact:_____
Name (Relationship to student) (Area Code) Phone Number

I understand that I may be asked to submit additional data. I understand that any falsification or omission of information can result in my dismissal from the health science program.

Student's Signature:	Date:	Student I.D. #

TO BE COMPLETED BY EXAMINER

Systems Reviewed	Normal Findings	
Blood Pressure	❑ Yes	❑ No
Temp	❑ Yes	❑ No
Height	❑ Yes	❑ No
Weight	❑ Yes	❑ No
Vision	❑ Yes	❑ No
Hearing	❑ Yes	❑ No
ENT	❑ Yes	❑ No
Respiratory	❑ Yes	❑ No
Cardiovascular	❑ Yes	❑ No
GI	❑ Yes	❑ No
GU/Reproductive	❑ Yes	❑ No
Neuro/Muscular	❑ Yes	❑ No
Endocrine	❑ Yes	❑ No
Integumentary	❑ Yes	❑ No

Do you consider this person to be physically and emotionally capable of performing the essential tasks required?

❑ Yes ❑ No

Examining Physician/Nurse Practitioner Signature:

_____

Date: _____

PRINT

Practitioner/Facility Name and Address: Phone: ( ) _____

LABORATORY TESTS AND IMMUNIZATIONS

Student Name:_____ Student ID:_____ Program:_____

PLEASE INITIAL EACH SECTION AND SIGN BOTTOM OF PAGE

To be completed by Health Care Practitioner

I.

Tuberculin Skin Test	Date Administered:	Date Read:	❑ Positive ❑ Negative
OR			
Quantiferon Gold Test	Date Drawn:	Date Read:	❑ Positive ❑ Negative
OR			
Chest X-Ray	Date:		❑ Positive ❑ Negative

II.

If born after 1/1/57, must have proof of two (2) MMR vaccines after age one (1).			
MMR Vaccine	Date:	Date:	
OR			
Rubella Titer	Date:	❑ Immune	❑ Not Immune
Rubeola Titer	Date:	❑ Immune	❑ Not Immune
Mumps Titer	Date:	❑ Immune	❑ Not Immune

III.

Tetanus/Diptheria/Pertussis		Date:	❑ Valid within the last 7 years	
OR	Tetanus Titer	Date:	❑ Immune	❑ Not Immune
	Diptheria Titer	Date:	❑ Immune	❑ Not Immune
	Pertussis Titer	Date:	❑ Immune	❑ Not Immune

IV.

Hepatitis B Vaccine	Date:	Date:	Date:	Surface Antibody Test: ❑ Positive ❑ Negative
OR	Heplisav B Vaccine	Date:	Date:	Surface Antibody Test: ❑ Positive ❑ Negative
OR	Hepatitis B Titer	Date:		❑ Immune ❑ Not Immune

OR

Sign declination if all immunizations and Surface Antibody Test are not complete or titer results were negative.

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

Signature (if declining) _____

V.

Varicella Titer	Date:	❑ Immune ❑ Not Immune
OR		
Varicella Vaccine	Date:	
	Date:	

VI.

Influenza (Flu) Vaccine	Date:

VII.

I certify that the above tests and/or vaccinations were performed in this office or laboratory, or documentation was provided to me by the patient.

(If the above tests and/or vaccinations were *not* performed in this office, documentation of agency performing the tests and/or immunizations is provided).

Licensed Health Care Practitioner Signature:_____ License #: _____

Print Name:_____ Date: _____