INDIAN RIVER STATE COLLEGE

Health Science Division

PHYSICAL EXAMINATION DIRECTIONS

IMMUNIZATIONS MAY TAKE 60 DAYS TO COMPLETE, PLEASE PLAN ACCORDINGLY

DIRECTIONS

1. Student and Health Care Practitioners please read all directions.
2. Student to complete top portion of the Annual Physical Form.
3. Health Care Practitioner to complete the bottom portion of pages 2, 3 and 4 of the form, sign, and date, including the complete address and phone number of the facility.
4. Student is to ensure all information is accurate on the form and submitted to Complio by due dates.
5. Review Performance Standards for Admission & Progression.
6. The only Health Care Practitioners who may sign the Physical Assessment form are Physician, PA, DO, or APRN.

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, must be completed annually. (Cannot be a Chiropractor.)**
3. **Tuberculin Test:** Follow your provider's process for a Tuberculin Skin Test. This test must be completed **annually**.
    - If results are negative, no further action is needed.
    - If results are positive (via skin test or Quantiferon Gold), provide a chest X-ray, or
    - If you've had a positive chest X-ray in the past, complete the symptom-free checklist.

BACK OF FORM

I. **MMR (Measles, Mumps, Rubella):** If born after 1/1/57, two MMR vaccines after age one are required.
    a. Proof of two vaccines (one month apart), or
    b. proof of immunity by titer, or
    c. exempt if born before 1/1/57.

II. **TDAP (Tetanus/Diphtheria/Pertussis):**
    a. Proof of immunization within the last seven years. (If the Tetanus expires during the semester, it must be updated before registration.)

III. **Hepatitis B Vaccination:**
    a. **Two Heplisav-B vaccines** and a **positive surface antibody** titer 1 month after all doses, or
    b. **Three Hepatitis B vaccines** and a **positive surface antibody titer** 1 month after all doses, or
    c. **Positive Hepatitis B titer**, or
    d. If none of the above are available, submit a **signed Hepatitis B vaccine declination form**.

IV. **Varicella (Chickenpox) Status:**
    a. History of chickenpox with **a positive titer**, or
    b. **two doses** of the **Varicella vaccine**.

V. **Annual Influenza (Flu) Vaccine:**
    a. Required every year around flu season.

VI. **Provider Verification:**
    a. A physician or nurse practitioner must **initial each completed section** and **sign/date at the bottom.**

CORE PERFORMANCE STANDARDS

Health Science programs involve the provision of direct care for individuals and are characterized by the application of knowledge in the skillful performance of certain functions. Therefore, in order to be considered for admission or to remain enrolled in a program after admission, all students must be able to demonstrate the following abilities:

Issue	Standard	Examples of Necessary Activities (not all inclusive)
Critical Thinking/ Coping	Critical thinking ability sufficient for clinical judgment. Ability to make fast decisions in stressful situations in a professional manner.	Identify cause-effect relationships in clinical situations; display good coping mechanisms.
Interpersonal	Interpersonal abilities sufficient to interact with individuals, families, and groups from a variety of social, emotional, cultural, and intellectual backgrounds.	Establish rapport with patients/clients and colleagues.
Communication	Communication abilities sufficient for interaction with others in verbal and written form.	Explain treatment procedures; initiate health teaching; document and interpret clinical actions and patient/client responses; prepare and maintain records.
Mobility	Physical abilities sufficient to move from room to room and maneuver in small spaces.	Move around in exam rooms, workspaces, and treatment areas; administer cardiopulmonary procedures.
Motor Skills	Gross and fine motor abilities sufficient to provide safe and effective patient care.	Calibrate and use laboratory, medical, and office equipment; position patients/clients.
Visual	Visual ability sufficient for observation and assessment necessary in care of the client.	Observe patient/client responses. Read lab slips. Prepare and administer medication accurately.
Tactile	Tactile ability sufficient for physical assessment.	Perform palpation, sense temperature change, assess pulses.
Hearing	Auditory ability sufficient to monitor and assess health needs, and perform office duties.	Hear blood pressure accurately, alarms, emergency signals, auscultatory sounds, answer phone.

*Adapted from the Board of Directors of the Southern Council on Collegiate Education for Nursing (SCCEN) guidelines for Nursing Education Programs.

To meet the requirements for graduation, students enrolled in or admitted to a Health Science program must be physically and emotionally capable of performing the essential tasks necessary for participation in classroom, laboratory, and clinical settings. Based on the above PSAP, do you consider this individual physically and emotionally capable of performing these essential tasks?

❑ Yes ❑ No

Examiner Signature: _____ Date: _____

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	☐ Surgical Services Technology
☐ Medical Assisting	☐ Central Service Technology
☐ Medical Lab Technology	☐ Pharmacy Technician
☐ Phlebotomy	☐ Phy. Therapist Asst (PTA)
☐ Radiography	☐ Respiratory Care

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 ANNUALLY

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

Annual Tuberculin Screening:

☐ PPD (Tuberculin Skin Test) **OR** ☐ IGRA (Quantiferon Gold Test)

Date Administered: _____ Date Read: _____
☐ Positive ☐ Negative

OR

☐ Chest X-Ray
Date Administered: _____
☐ Positive ☐ Negative

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, Rows must be completed in their entirety

I. MMR

If born after 1/1/57, must have proof of two (2) MMR vaccines after age one (1).		
MMR Vaccine (2-dose)	Date:	Date:

OR

Rubella Titer	Date:	❑ Immune ❑ Not Immune
Rubeola Titer	Date:	❑ Immune ❑ Not Immune
Mumps Titer	Date:	❑ Immune ❑ Not Immune

II. TDAP

Tetanus/Diphtheria/Pertussis	Date:	❑ Valid within the last 7 years

OR

Tetanus Titer	Date:	❑ Immune ❑ Not Immune
Diphtheria Titer	Date:	❑ Immune ❑ Not Immune
Pertussis Titer	Date:	❑ Immune ❑ Not Immune

III. Hepatitis

Hepatitis B Vaccine (3-dose)	Date:	Date:	Date:	Surface Antibody Test: ❑ Positive ❑ Negative

OR

Heplisav-B Vaccine (2-dose)	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) _____

IV. Varicella

Varicella Titer	Date:	❑ Immune ❑ Not Immune

OR

Varicella Vaccine (2-dose)	Date:
	Date:

V. Influenza

Influenza (Flu) Vaccine	Date:

VI. Provider Verification

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: _____

IRSC is an EA/EO educational institution.