Physical Examination and Immunization Form

Health Sciences Student Information Sheet

INDIAN HILLS COMMUNITY COLLEGE
Life. Changing.

TO BE COMPLETED BY THE STUDENT: Birthdate (mm/dd/yy): __ __ / __ __ / __ __

Last Name: _____ First Name: _____ Middle: _____

Address: _____ City: _____ State: _____ Zip: _____

How do you rate your general health? _____

Do you have any physical or emotional limitations that might hinder your ability to perform the duties and responsibilities of the program you have selected? ☐ Yes ☐ No

If yes, please explain:

Student Signature: _____ Date: _____

Health Sciences Program: _____

Immunizations and Tests: This portion of the form must be filled out in its entirety. Blanks are not allowed. All immunization data must be on this form **OR** the Iowa Department of Public Health form (IRIS) **OR** another State's official public health form.

MMR: All persons born after 1/1/57 must have received 2 injections of MMR vaccine at least one month apart and after their first birthday **OR** have sufficient rubeola, mumps, and rubella titer **OR** Physician documentation of acquired disease.

#1 Date: _____

#2 Date: _____

Rubeola Titer Date: _____ ☐ Immune ☐ Not immune

Mumps Titer Date: _____ ☐ Immune ☐ Not immune

Rubella Titer Date: _____ ☐ Immune ☐ Not immune

If you have had a titer, you must upload the lab report.

COVID 19 VACCINATION (2 doses of Moderna or Pfizer or 1 dose J&J required) OR approved exemption form

1st Dose Date: _____ Lot #: _____

Location/Facility/Provider: _____

Manufacturer: ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson

2nd Dose Date: _____ Lot #: _____

Location/Facility/Provider: _____

Manufacturer: ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson

Booster Date: _____ Lot #: _____

Location/Facility/Provider: _____

Manufacturer: ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson

OR Approved exemption form provided

Tetanus/Diphtheria/Pertussis Booster-TDAP
(Must be within 10 years of graduation date)
(Age 18 years or older)

Date: _____

Booster

Date: _____

Hepatitis B: See information sheet.

#1 Date: _____

#2 Date: _____

#3 Date: _____ or

Titer date **(upload lab report)**: _____ or

If you choose NOT to receive Hepatitis B vaccine, your signature declining vaccination is required.

_____

Student Signature Date

Varicella (Chickenpox):

Titer positive for chicken pox or shingles – **Must upload lab report.** Date of titer: _____

OR

Varicella Vaccine #1 Date: _____ and Varicella Vaccine #2 Date: _____

Two-step TB Testing (PPD):

Have you ever had a positive TB reaction?	☐ Yes	☐ No
Are you currently taking corticosteroids?	☐ Yes	☐ No
Or immunosuppressive agents?	☐ Yes	☐ No
In the past 6 weeks have you had immunizations for measles, mumps, rubella, or influenza?	☐ Yes	☐ No
Have you had a TB test in the last year?	☐ Yes	☐ No

If yes and you can provide documentation, you will only require one additional TB test.
A minimum of 1 week is required between TB tests. A maximum of 3 weeks is allowed between tests.

I have been informed of the risks of receiving this intradermal injection and my questions have been answered.
I understand that it is my responsibility to have the test **read 48-72 hours** after the test has been given.

Print Name: _____

Student Signature: _____ Date: _____

If history of positive test, chest x-ray follow up (date within 1 year) _____ **Must upload x-ray report.**

OR QuantiFERON gold test _____ **Must upload lab report.**

Test #1:

_____
Injection Given By

_____ _____ _____
Lot # Exp. Date Date Given

Reaction Test #1: Read induration only, not redness

_____ mm's Date Read: _____

This reaction is seen as _____ according to the Iowa Department of Health criteria

_____
Health Provider Signature Date

Test #2:

_____
Injection Given By

_____ _____ _____
Lot # Exp. Date Date Given

Reaction Test #2: Read induration only, not redness

_____ mm's Date Read: _____

This reaction is seen as _____ according to the Iowa Department of Health criteria

_____
Health Provider Signature Date

TO THE EXAMINER: While enrolled in a health sciences program at Indian Hills Community College, this student may be involved in: a rigorous academic program; stressful situations in a one-on-one basis or in groups; activities requiring average manual dexterity, ability to lift, move, or turn person weighing at least as much as the student; activities requiring use of all sense organs, and activities which requires the student to be on her/his feet for up to eight consecutive hours.

Physicals must be completed by a physician (M.D. or D.O.), physician's assistant (PA) or nurse practitioner (ARNP).

I hereby certify that I have examined the person named above and determined that she/he is physically and emotionally fit to be enrolled as a student in her/his chosen program at Indian Hills Community College **and has had all the immunizations required**.

Comments: _____

Printed Name: _____

Address of Healthcare: _____

Provider Signature: _____ Date: _____

Must provide front and back of form to Castlebranch or to your Program's designated faculty if your Program does not utilize Castlebranch.
Falsification of medical records will result in disciplinary action which may include dismissal from the Program.
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