INDIAN HILLS COMMUNITY COLLEGE
Life. Changing.

Student Name (print)

Last Name **First Name** **Middle Name**

Date of Birth: _____

Student Medical History and Physical

This form MUST be completed and signed by a Health Care Provider (MD, DO, PA or ARNP) who is not a family member		**Date of Examination:**
Pulse:	**Blood Pressure:**	
Allergies: **YES** **NO**	☐ **Medications** _____ ☐ **Latex** _____ ☐ **Food** _____ ☐ **Other** _____	
Med-Alert Condition:		

Clinical Evaluation

	General Good Health	**Fair Health** Describe restrictions or concerns in space below by system.	**Poor Health** Describe restrictions or concerns in space below by system.
Neurological			
EENT			
Respiratory			
Cardiac			
Gastrointestinal			
Immunological			
Musculoskeletal			

Health Care Statement

I have examined: _____ **Date of Birth:** _____
Print Student's: **Last Name** **First Name** **MI** **00/00/0000**

☐ **I find her/him physically able to participate in a Health Science Program at Indian Hills Community College and the student is in** _____ **health.**
(Insert: good, fair, or poor)

HCP Name (print) _____ **HCP Title:** _____

Signature: _____ **Date:** _____

Clinic/Office Stamp (REQUIRED):

Student Name (print) _____ Birth Date: _____

Required Test and/or Immunizations

This form is to be completed, signed, and dated by a licensed health care provider (MD, DO, ARNP, PA) who is not a family member. Take your immunization records and documentation of disease with you to your appointment. If immunization records are not available, the HCP will determine what vaccinations tests or titers are indicated. **Documentation of the items below are required by the clinical agencies Indian Hills Community College contracts with for clinical experience.**

TB Skin Test - PPD by Mantoux (not Tine) within the last 12 months. Blood Test (QuantiFERON Gold is accepted; results must be uploaded to Viewpoint). **One Annual TB skin test is required once 2-Step has been met.**

	Date & Time Administered mm/dd/yy	Date &Time Read mm/dd/yy	Results: mm of induration & signature of who read the results.
#1 Skin Test			
#2 Skin Test Must be more than 7 days but less than 1 year between the #1 and #2 skin test.			

If Positive PPD, Chest X-ray report must be uploaded to Viewpoint

Is treatment plan indicated? Check one ☐ Yes – attached ☐ No

Adult Diphtheria/Tetanus/Pertussis Vaccine must include Pertussis component.	Date of Tdap mm/dd/yy

Varicella (Chicken Pox) – Evidence of immunity includes any of the following:

- **Positive titer with lab results uploaded to Viewpoint.**
- **Two doses of the vaccine**

Past history of chickenpox is not acceptable.

Vaccination #1 mm/dd/yy	Vaccination #2 mm/dd/yy	Must upload a copy of the lab results to Viewpoint.

Hepatitis B – Evidence of immunity includes any one of the following:

- **Completion of series, OR Positive Titer of HBsAB**

If you chose NOT to receive the Hep B vaccine your signature declining this vaccination is required.

Student's Signature: _____ **Date:** _____

First dose must be documented prior to submission of this health record and written verification of additional doses submitted as received.

Vaccination #1 Required prior to submitting this record. mm/dd/yy	Vaccination #2 (1-2 months) mm/dd/yy	Vaccination #3 (4-6 months) mm/dd/yy

MMR – All students, regardless of age, must have documentation of either 2 MMR vaccinations OR documentation of sufficient titers for Rubeola, Mumps and Rubella. Those who have an "indeterminate" or "equivocal" level of immunity upon testing should be considered non-immune. **Lab results of titers must be uploaded to Viewpoint.**

Titers	Titer Date mm/dd/yy	Titer results –		If born 1957 or later, 2 doses of live measles and mumps vaccines given on or after the first birthday, separated by 28 days or more.	
Rubeola IgG		Must upload results to Viewpoint		MMR Vaccination #1 mm/dd/yy	MMR Vaccination #2 mm/dd/yy
Mumps IgG		Must upload results to Viewpoint			
Rubella		Must upload results to Viewpoint			

I certify this student has received the TB test and immunizations as indicated above or has laboratory evidence of immunity which is attached to this form.

Print Name of Health Care Provider: _____

_____ **Date:** _____

Signature of Health Care Provider (MD, DO, ARNP, PA) who is not a family member.