INDIAN HILLS COMMUNITY COLLEGE

Life. Changing.

Health Sciences Physical Examination & Immunizations

TO BE COMPLETED BY THE STUDENT: SSN ___-__-____ **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 Science Program**

Immunizations and Tests: Note recommendations on information sheet. This portion of the form must be filled out in its entirety. Blanks are not allowed. All immunization data must be on this form. **DO NOT** submit other documents as proof.

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

MMR OR Rubella Titer if born BEFORE 1/1/57

MMR Date:_____
OR
Rubella Titer Date: _____

Immune Not immune

If Not Immune, then Rubella Vaccine (proof of two vaccinations)

#1 Date:_____

#2 Date:_____

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

Date:_____

Booster

Date:_____

Hepatitis B: **See information sheet**
#1 Date:_____
#2 Date:_____
#3 Date:_____ or
Titer: _____ or
If you choose NOT to receive Hepatitis B vaccine, your signature declining vaccination is required.

_____
Student Signature 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.

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) _____ or QuantiFERON gold test _____

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 _____

Varicella (Chickenpox): See information sheet

Have you had chickenpox? ☐ Yes ☐ No Titer positive for chicken pox or shingles: _____

Varicella Vaccine #1: _____ If born after 1980, Varicella Vaccine #2 _____
Date Date

If you have not had chickenpox and choose not to receive the varicella vaccine, your signature declining vaccination is required.

Student Signature _____ Date _____

Influenza Vaccine (October through March):

Date: _____ Dr. Office/Employer: _____

Date: _____ Dr. Office/ Employer: _____

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: _____