INDIANHILLS
COMMUNITY COLLEGE
Life. Changing.

Health Sciences Physical Examination & Immunizations

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 Science 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	COVID 19
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: _______________ Manufacturer (circle one): Pfizer Moderna Johnson&Johnson Lot number:_____________Location/Facility/Provider: _______ 2nd Dose: Date:______________ Manufacturer (circle one): Pfizer Moderna Johnson&Johnson Lot number:______________Location/Facility/Provider: _______ Booster: Date:______________ Manufacturer (circle one): Pfizer Moderna Johnson&Johnson Lot number:_____________Location/Facility/Provider: _______ **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.