INDIAN RIVER STATE COLLEGE
HEALTH SCIENCE DIVISION

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Physical Examination

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

Blood Pressure  TPR  Height  Weight  Hair Color  Eye Color

VISION:
Right Eye with corrective lens  Without corrective lens
Left Eye with corrective lens  Without corrective lens

HEARING:  Right Ear  Left Ear

REVIEW OF SYSTEMS:  (+) = Positive Findings  (-) = Negative Findings

ENT  GU/Reproductive
Respiratory  Neuro/Muscular
Cardiovascular  Endocrine
GI  Integumentary

EXPLANATION OF POSITIVE FINDINGS:  

List all prescription medication including frequency, route and dosage  

Do you consider this person to be physically and emotionally capable of performing the essential tasks required?
☐ Yes  ☐ No

Remarks:  

Examining Physician/Nurse Practitioner Signature:  Date:

PRINT  Name and Address:  Phone:  (   )

IRSC 515 (Rev. 2/09)
LABORATORY TESTS AND IMMUNIZATIONS

To be completed by Health Care Practitioner

I. Mantoux PPD/Tuberculin Test  Date:  Results:  OR  
   Chest X-Ray  Date:  Results:  

II. If born after 1/1/57, must have proof of two (2) MMR vaccines after age one (1).  
   MMR Vaccine  Date:  Date:  OR  
   Rubella Titer  Date:  Results:  
   Rubeola Titer  Date:  Results:  
   Mumps Titer  Date:  Results:  

III. Tetanus/Diphtheria/Pertussis  Date:  OR  
   Tetanus Titer  Date:  Results:  
   Diphtheria Titer  Date:  Results:  
   Pertussis Titer  Date:  Results:  

IV. Hepatitis B Vaccination  Date:  Date:  Date:  OR  
   and test for Surface Antibody (1-2 months after Dose #3)  Date:  
   OR  
   Hepatitis B Titer  Date:  Results:  OR  

Please sign declination if all three (3) immunizations are not complete.  

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) ________________________________  

V. Varicella Status  History of Varicella (Chickenpox)  Date:  OR  
   Varicella Titer  Date:  Results:  OR  
   Varicella Vaccine  Date:  Results:  

VI. 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: ___________________________