PHYSICAL EXAMINATION DIRECTIONS

IMMUNIZATIONS MAY TAKE 30 DAYS TO COMPLETE, SO MAKE AN APPOINTMENT AS SOON AS POSSIBLE.

FRONT OF FORM

1. Student to complete the top portion of the form.
2. Physician or nurse practitioner to complete the bottom portion of the form, sign, and date, including the complete address and phone number of the facility. Form will not be accepted without this information completed. (Cannot be a Chiropractor.)

BACK OF FORM

I. Tuberculin Test: Follow your healthcare provider’s procedure for Tuberculin Skin Testing Method. If Tuberculin Skin Test or Quantiferon Gold Test is positive, have chest X-ray taken or complete the symptom-free checklist if you have had a positive chest x-ray in the past. This test is valid for one year from the time of reading, and must be valid through the end of each semester. (If the TB expires during the semester, it must be updated prior to registering for the semester.)

II. MMR: (Measles, Mumps, Rubella Vaccine) - Proof of two vaccines (physician requires that there be one month between vaccines), or proof of immunizations by titer, or exempt from vaccine if born before 1/1/57. If born after 1/1/57, must have proof of two (2) MMR vaccines after age one (1).

III. Tetanus/Diphtheria/Pertussis: Proof of immunization within the last seven years. (If the Tetanus expires during the semester, it must be updated prior to registering for the semester.)

IV. Hepatitis B Vaccination: Proof of all three immunizations and positive surface antibody test 1-2 months after dose #3, or Positive Hepatitis B Titer or signature to decline immunization at this time.

V. Varicella Status: Known history of chickenpox with positive Varicella Titer, or 2 doses of the Varicella Vaccine.

VI. Physician or Nurse Practitioner must initial each section where data is entered then sign and date at the bottom.

All health information that is not documented on health forms must have:

1. Letterhead from institution or physician or nurse practitioner.
2. Signature of physician or nurse practitioner.
3. Date immunization or update was given.
### Physical Examination

<table>
<thead>
<tr>
<th>Systems Reviewed</th>
<th>Normal Findings</th>
<th>Normal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Temp</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Height</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>GI</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>GU/Reproductive</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Neuro/Muscular</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Endocrine</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Integumentary</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
</tbody>
</table>

**Do you consider this person to be physically and emotionally capable of performing the essential tasks required?**

□ Yes □ No

**Examing Physician/Nurse Practitioner Signature:**

______________________________

Date: ________________________

---

**INDIAN RIVER STATE COLLEGE**

**HEALTH SCIENCE DIVISION**

This record becomes College property. Students must make personal copies prior to submission; copies will not be provided once submitted. Note: This information may be shared with clinical agencies.

---

**Health Science Program: Select One**

- Dental Assisting Technology
- Dental Hygiene
- EMT/Paramedic
- Health Care Management
- Health Info Technology
- Medical Assisting
- Medical Lab Technology
- Nursing Assistant
- Nursing (ADN)
- Nursing (BSN)
- Pharmacy Technician
- Phlebotomy
- Phy. Therapy Asst. (PTA)
- Practical Nursing (LPN)
- Radiography
- Respiratory Care
- Surgical Technology

---

**TO BE COMPLETED BY STUDENT BEFORE EXAMINATION**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First</th>
<th>Middle</th>
<th>(Area Code) Home Phone</th>
<th>Birth Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>Apt.</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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**

**PRINT**

Practitioner/Facility Name and Address: __________________

Phone: ( )
# LABORATORY TESTS AND IMMUNIZATIONS

To be completed by Health Care Practitioner

## I. Tuberculin Skin Test
- **Date Administered:**
- **Date Read:**
  - [ ] Positive
  - [ ] Negative
  
  OR

## II. Quantiferon Gold Test
- **Date Drawn:**
- **Date Read:**
  - [ ] Positive
  - [ ] Negative
  
  OR

## III. Chest X-Ray
- **Date:**
  - [ ] Positive
  - [ ] Negative

## II. If born after 1/1/57, must have proof of two (2) MMR vaccines after age one (1).

### MMR Vaccine
- **Date:**

  OR

### Rubella Titer
- **Date:**
  - [ ] Immune
  - [ ] Not Immune

### Rubeola Titer
- **Date:**
  - [ ] Immune
  - [ ] Not Immune

### Mumps Titer
- **Date:**
  - [ ] Immune
  - [ ] Not Immune

## IV. Tetanus/Diptheria/Pertussis
- **Date:**
  - [ ] Valid within the last 7 years
  
  OR

### Tetanus Titer
- **Date:**
  - [ ] Immune
  - [ ] Not Immune

### Diptheria Titer
- **Date:**
  - [ ] Immune
  - [ ] Not Immune

### Pertussis Titer
- **Date:**
  - [ ] Immune
  - [ ] Not Immune

## V. Hepatitis B Vaccine
- **Date:**
  
  OR

### Hepatitis B Titer
- **Date:**
  - [ ] Immune
  - [ ] Not Immune

  OR

### Hepatitis B Titer
- **Date:**
  - [ ] Immune
  - [ ] Not Immune

## VI. Varicella Titer
- **Date:**
  - [ ] Immune
  - [ ] Not Immune

  OR

## V. Varicella Vaccine
- **Date:**

## 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: ____________________________

IRSC is an EA/EO educational institution.