Iowa Lakes Community College
Nursing Program
Physical Exam Form

Physical Examination and Immunizations: Must be completed and signed by physician, nurse practitioner, or physician assistant (within 6 months of entry and every 3 years)

Name _____ Date of Birth _____ Date _____

Address _____ Male _____ Female _____

Program _____ Allergies _____

Does this applicant have any communicable diseases, physical limitations, or mental condition which would prevent him/her from entering this occupational field? If yes, please explain _____

Need for physical limitation waiver? YES / NO If yes, identify limitation _____

PHYSICAL EXAMINATION		IDENTIFY PHYSICAL LIMITATIONS
Present Complaints		
Weight & Height		
TPR, BP		
Snellen Corrected	Rt. Lt.	
Color Vision		
Eyes		
Ears	Rt. Lt.	
Nose		
Teeth		
Throat		
Neck		
Heart		
Lungs		
Breast		
Abdomen		
Hernias		
Back (Posture)		
Skin		
Extremities		
Varicose Veins		
Glands		
Neurological Exam		

Provider's Signature _____ **MD/DO, ARNP/PA-C** Date _____

Address _____

Name _____ Date of Birth _____

REQUIRED IMMUNIZATIONS/TESTING: Please indicate dates on which immunizations/testing were completed. If immunization records are unavailable, serum titers may be used to document immunity. Physicians must determine immunity and indicate in the appropriate area below.

I. Tuberculosis: Proof of a two-step Tuberculin skin test or QuantiFeron Gold® test within the last six months prior to entry to the Nursing Program. After receiving the two-step, the students will be required to have an annual TB test.
   1) If any of the tests are **positive** or reactive, the student must submit **one** of the following:
      a) Clear chest x-ray report OR
      b) Completed TB Conversion Assessment form OR
      c) A physician or physician designee statement approving the student's TB status for client contact
   2) For students that who have received the BCG (bacilli Calmette-Guerin) vaccine must be tested with the QuantiFeron Gold® test.
   3) If any student reports signs, symptoms, or exposure to TB they must be evaluated by their health care provider and given approval to attend class and clinical.

Tuberculin Skin Test (Mantoux) Two-Step	Reactive ❑	Non-reactive ❑	_____/_____/_____
	Reactive ❑	Non-reactive ❑	_____/_____/_____
QuantiFERON Gold® Test	Positive ❑	Negative ❑	_____/_____/_____
Annual Tuberculin Skin Test (Mantoux)	Reactive ❑	Non-reactive ❑	_____/_____/_____

II. **Measles, Mumps, Rubella (MMR)** – Proof of immunity by vaccination (two doses) of MMR or positive blood titer for all three diseases. Note: The first dose must be after your first birthday and in 1957 or later. The second dose must be at least 28 days after the first dose (usually given at age 4-6 year or later). If a titer is negative, you must receive a booster vaccine and provide evidence of a positive titer.

	MMR Dose 1		_____/_____/_____
	MMR Dose 2		_____/_____/_____
Measles Titer	Immune ❑	Non-immune ❑	_____/_____/_____
Mump Titer	Immune ❑	Non-immune ❑	_____/_____/_____
Rubella Titer	Immune ❑	Non-immune ❑	_____/_____/_____

III. **Tetanus/Diphtheria/Pertussis (Tdap) –** Proof of vaccination within the last 10 years. _____/_____/_____

IV. **Chicken Pox (Varicella)** – One of the following is required: 2 vaccinations (28 days apart) OR positive antibody titer.

	Varicella Dose 1		_____/_____/_____
	Varicella Dose 2		_____/_____/_____
Varicella Titer	Immune ❑	Non-immune ❑	_____/_____/_____

V. **Hepatitis B Vaccine Series –** Proof of vaccination series (three doses), or positive blood titer. If you have received the Hepatitis B vaccine and do not have documentation, a blood titer will be required. Before students can start clinical, at least two vaccines will be required if they will be working with patients or may come into contact with blood and/or body fluids.

Dose 1 _____/_____/_____
Dose 2 _____/_____/_____
Dose 3 (CDC recommends a titer 1-2 months after 3rd dose to determine immunity) _____/_____/_____
If you have received the Hepatitis B vaccine and do not have documentation, a blood titer will be required.

Hepatitis B Titer	Immune ❑	Non-immune ❑	_____/_____/_____

VI. **Influenza:** Vaccination is required no later than October 1st for fall entry students and March 31st. Clinical facilities may have other requirements. _____/_____/_____

RECOMMENDED IMMUNIZATION:

I. **Meningitis Vaccine -** All college students receive the Iowa Lakes Community College Student Handbook which includes Meningitis information, and may choose to receive or decline the vaccine. _____/_____/_____

Physician or Physician Designee Signature _____

Iowa Lakes Community College
Nursing Program

TB Conversion Assessment
Self Report

NAME:_____
Print

The TB Conversion Assessment form must be completed every year after a positive or reactive test if a chest x-ray or physician or physician designee statement is not obtained.

During the past 12 months, have you had any of the following:

1. Persistent fever or night sweats? YES NO

2. Chronic cough? YES NO

3. Coughed up blood? YES NO

4. Unexplained weight loss? YES NO

Please promptly report any of the above signs or symptoms suggestive of active TB disease to your health care provider and Director of Nursing Education.

Students who have a history of a positive TB skin test (Mantoux) or QuantiFERON Gold® Test, must complete the following.

Date of positive TB test: _____

Were you treated with medication? If no, explain _____
_____

Date of chest x-ray _____

Results of chest x-ray (include x-ray results and/or physician's report) _____
_____

_____ _____
Student Signature Date

Reviewed: September 17, 2018

Iowa Lakes Community College
Nursing Program
Waiver of Liability

To be submitted to the Nursing Program Office if there are impairments or limitations.

I, _____, am fully aware and knowledgeable of my physical impairment or limitation. Being knowledgeable of this impairment, I likewise assume all responsibility and liability for my actions or acts. Consequently, I release Iowa Lakes Community College and the clinical facilities of any liability, which could occur if I should not adhere to the limitations prescribed while engaging in classroom and/or clinical functions of the Nursing Program in which I am currently enrolled.

Description of the limitation (to be filled out by Health Care Provider):

_____

_____

_____

_____

_____
(Student Signature/Date)

_____
(Health Care Provider Printed Name/Date)

_____
(Health Care Provider Signature/Date)

_____
(Nursing Program Signature/Received Date)

Revised: February 11, 2019