NORTH IOWA AREA COMMUNITY COLLEGE
HEALTH RELATED PROGRAMS
PHYSICAL EXAMINATION AND IMMUNIZATION RECORD

Student's Name: _____
Last First Middle

Address: _____
No. & Street City State Zip

Telephone No.: (_____)_____ Date of Birth: _____/_____/_____
Mo. Day Year

Please indicate program entering:

_____ Associate Degree Nursing	_____ Practical Nursing	_____ Physical Therapist Assistant
_____ Medical Assistant	_____ Emergency Medical Responder	_____ Emergency Medical Technician
_____ Advanced Emergency Medical Tech	_____ Phlebotomy	

This physical form consists of three parts: Immunizations and Tests, Medical History, and the Medical Examination. Each section **must** be completed **and** signed in the yellow areas before you are allowed to proceed into the clinical area. These immunizations and tests are required for compliance with the contractual agreements of our participating clinical agencies. Additional immunizations or tests may be requested by facility contracts and the student will be required to comply with these requirements.

The following is an explanation for the immunizations and tests listed in Part I: Immunizations and Tests that are required for NIACC Health Division students:

1. **MMR (Measles, Mumps, Rubella):** A **two** vaccine series is required for all individuals or serological proof of immunity of **all three** diseases.

2. **Tdap (Diphtheria, Tetanus, Pertussis):** Please document your dates for the diphtheria, tetanus and pertussis vaccine. Boosters for Tetanus must be within the last ten years and maintained throughout the program. Pertussis vaccine requirements should be reviewed with the physician.

3. **TB (Tuberculin):** All health students will require a two-step TB test (or lab report) upon program entry. Thereafter, one of the following will be required: 1.) annual TB testing - any lapse of greater than 12 months requires repeat two-step testing. 2.) A lab report is required for a QuantiFERON TB Gold Blood Test. A history of a positive finding will require a baseline chest x-ray and a TB Assessment Form. Please upload testing results to the Viewpoint Screening Health Portal. The student will be responsible to maintain current TB test results throughout the program.

4. **Varicella-Zoster:** A titer or the vaccine is required. A **two** vaccine series one month apart is required if the titer status is non-immune.

5. **Hepatitis B:** The vaccination is strongly encouraged. If you do not plan on obtaining the series, please sign the waiver on the back page. You will be required to provide the dates for each vaccination. If you are in the process of obtaining the series, it is your responsibility to provide the dates as the vaccinations are received.

6. **Influenza:** The vaccine during the current flu season (October 1 - March 31) or a signed declination and/or medical/religious waiver, dependent on clinical requirement, is required. Out-of-Season Influenza Waiver Form must be completed and uploaded into Viewpoint Screening Health Portal (April 1 - September 30).

7. **COVID-19:** The latest season/year vaccine or signed declination and/or medical/religious waiver, dependent on clinical requirement, is required.

8. Agency specific requirements for vaccination as announced.

Physical and immunization/testing results will be compiled after program orientation and before clinical rotation. The student will be independently responsible for maintaining current status for immunization testing. Failure to comply with these requirements will result in removal from the clinical settings.

The student is responsible for notifying instructors and the NIACC Health Division Chairperson of any changes in this physical form.

STUDENT NAME: _____

PART I: IMMUNIZATIONS AND TESTS

This section is to be completed by the student and/or physician or physician extender **AND** **SIGNED** by a representative of a health care agency in the yellow area indicated below. Clinical affiliations require that our students provide evidence of the following prior to beginning the clinical rotations. Explanations for each of these immunizations and laboratory tests are provided on the previous page.

1) Two MMR vaccinations or proof of immunity of all three diseases.
2) Tetanus and Diphtheria boosters must be within the last ten years.
3) Tuberculin Skin Test: A copy of your TB skin test results or QuantiFERON TB Gold Blood Test lab report should accompany this physical form.
4) Varicella-Zoster Titer or documentation of two vaccinations. Please note recommendations previously stated on page 1 on this form.

1. MMR Vaccine (Two Dates) #1 Date _____ #2 Date _____	2. Tetanus/Diphtheria Date _____ (Boosters of Tetanus and Diphtheria must be within the last ten years) Pertussis Date _____ (If recommended by Health Care Provider)
3. Tuberculin Skin Test: #1 Date _____ #2 Date _____ **OR** Results:_____ QuantiFERON TB Gold Blood Test _____	4. Varicella-Zoster Titer Date_____ Results _____ OR Two (2) dates of vaccination: #1 _____ #2 _____
5. Hepatitis B #1 Date _____ #2 Date _____ #3 Date _____ Injections 2 and 3 must be reported when completed.	6. Covid-19 Current Year Vaccination Date_____ OR Declination/Medical/Religious waiver option: ☐

Physician/Physicians Assistant/Nurse Practitioner Signature: _____ Date:_____

PART II: MEDICAL HISTORY:

This section is to be completed **AND** signed by the student in the yellow area indicated below. Please answer all questions. Comment on all positive answers, including the year of occurrence. **If there is a change in the physical status, the student is responsible for notifying instructors and the Health Division Chairperson.**

Have you had/or currently have:	Yes	No	Comments
1. Hay Fever, Asthma			
2. Ear, Nose, Throat Trouble (include hearing and vision)			
3. Psychological or Emotional Disorder			
4. Convulsive Disorder			
5. Weakness, Paralysis			
6. Disease or Injury of Joints			
7. Back Problems			
8. Has your physical activity been restricted during the past five years? (Give reasons and durations)			
9. Have you had any serious illness or injury or been hospitalized other than already noted? (Give details)			
10. Have you had or are you a carrier of any infectious disease? If yes, provide a statement from physician under what conditions you can participate.			
11. Allergies/medications or others (e.g. latex):			

Student Signature: _____ Date: _____

STUDENT NAME: _____

PART III: MEDICAL EXAMINATION

To be completed by the physician or physician extender and signed in the indicated area below.

This student has been tentatively accepted into one of the following health programs at North Iowa Area Community College: Associate Degree Nursing, Practical Nursing, Physical Therapist Assistant, Medical Assistant, Emergency Medical Responder, Emergency Medical Technician, Advanced EMT, Phlebotomy. While enrolled, this student will be required to achieve in a very rigorous academic program; involved in very stressful situations on a one-to-one basis; called upon to work with groups of people in stressful situations; required to communicate effectively; auditory ability to monitor and assess, or document health needs; required to have visual acuity to distinguish anatomical structures and distinguish minor variations in color; required to use tactile sensations to palpate anatomical structures and distinguish variations in skin temperature; engaged in activities which require above average manual dexterity; expected to lift, pull/push up to 75 pounds, required to be on his/her feet for a maximum of twelve consecutive hours at one time. Please review the student's history and complete this form. Please comment on all positive answers. This information is strictly for the use of the Health Division and will not be released without the student's consent.

Vital Signs: TPR: _____ Height: _____

ABNORMALITIES	NO	YES	If yes, state conditions	GENERAL COMMENTS
1. Head, Ear, Nose or Throat				
2. Eyes				
3. Skin				
4. Respiratory				
5. Cardiovascular				
6. Gastrointestinal				
7. Hernia				
8. Genitourinary				
9. Musculoskeletal				
10. Metabolic/Endocrine				
11. Neuro/psychiatric				
12. Is this student now under treatment for any medical or emotional condition?				
13. Does the student have any mental or physical restrictions which would hinder his/her ability to undertake this program?				
14. List Present Medications:				

COMMENTS: _____

_____

_____

I hereby certify that I have examined _____ on _____ and that they are physically and emotionally fit to be enrolled as a student in a health program.

Physician Name (Print): _____ Signature: _____

Address: _____ Date: _____

_____ Telephone: _____

HEPATITIS B VACCINE INFORMATION SHEET

Hepatitis B is one of several viral infections of the liver. In the United States fifty to sixty percent of infected persons have no symptoms or a mild flu-like illness lasting only a few days. One to three percent of infected persons develop severe illness, progress to liver failure and die within two to three weeks of onset of the illness. Approximately ten percent of infected adults become carriers. Some persons develop chronic hepatitis which may last two to three years and sometimes results in death. A small percentage of infected persons develop life threatening liver diseases (cirrhosis and hepatocellular carcinoma) ten to twenty years after the initial infection.

MECHANISM OF EXPOSURE: The sources of exposure include any percutaneous and mucous membrane exposure to blood or any of the following: semen, vaginal secretions, CSF, synovial fluid, pleural fluid, pericardial fluid, amniotic fluid, or other body fluids if they contain visible blood. The most common method of exposure are needle sticks, cuts via bloody equipment, blood onto broken/chapped/or abraded skin, and splashes of infectious material into eyes/nose/or mouth.

HEPATITIS B VACCINE is a synthetic vaccine used to develop protection from the disease prior to exposure. It contains no substances of human origin. It is manufactured using the yeast, Saccharomyces cerevisiae.

INDICATIONS: Anyone with potential for exposure to blood, body fluids, and tissues of patients should consider receiving the vaccine.

CONTRAINDICATIONS: Anyone with an allergy to yeast, thimerisol, or any other component of the vaccine should not be vaccinated. Doses should be postponed during acute illness.

ADMINISTRATION: Vaccination with the Hepatitis B vaccine requires three doses which are injected into the deltoid muscle of the upper arm. The second dose is due one month after the initial dose. The third and last dose is due six months after the first.

EFFECTIVENESS: Approximately 95 percent of vaccinated persons develop the desired response to the vaccine. A fourth "booster" dose may produce antibodies in persons who fail to respond to the first three doses.

PREGNANCY AND NURSING: The effect of the vaccine on the unborn fetus or nursing infant is unknown. The vaccine is transmitted in mother's milk. If you are pregnant, planning a pregnancy, or nursing an infant, you will need special counseling about the vaccination program. This can be obtained from your physician.

ADVERSE REACTIONS: Hepatitis B vaccine is generally well tolerated. Soreness at the injection site is the most common side effect. Other reported side effects include but are not limited to the following: fatigue, fever, headache, dizziness, chills, influenza-like symptoms, nausea, vomiting, diarrhea, constipation, muscle aches, joint pains, rash, asthma-like symptoms, abnormal liver function tests, Guillian-Barre syndrome, Bell's palsy, and transverse myelitis.

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HEPATITIS B VACCINATION WAIVER

I understand that due to my occupational exposure to blood or other potentially infectious materials during my clinical practicum that I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the instruction I should be vaccinated with Hepatitis B vaccination at my own expense if my insurance company does not cover the cost. I also understand if I am currently working as an employee in a health facility and have a potential exposure to blood, that my employer is to cover the cost of the Hepatitis B vaccination. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. I hereby release North Iowa Area Community College and my clinical practicum site of any responsibility if I should contract Hepatitis B while I am a student. I also understand that by declining the vaccination that certain clinical sites may not accept me as a student.

_____ _____

(Print Name) (Student's Signature)

_____ _____

(Date) Parent or Guardian's Signature (if student Is a minor)

_____

(Program Enrolled In)

Rev. 5/2024