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 ___________________________

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<thead>
<tr>
<th>PHYSICAL EXAMINATION</th>
<th>IDENTIFY PHYSICAL LIMITATIONS</th>
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<td>Present Complaints</td>
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<td>Weight &amp; Height</td>
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<td>TPR, BP</td>
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<td>Snellen Corrected</td>
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<td>Back (Posture)</td>
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<td>Varicose Veins</td>
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<td>Glands</td>
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<td>Neurological Exam</td>
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Provider’s Signature ________________________________ MD/DO, ARNP/PA-C Date ________________

Address ____________________________________________
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.

I. Tuberculosis
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
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