Imperial Valley College

Student Health Center (760) 355-6310 / Fax (760) 355-5738

PHYSICAL FORM

Name:______________________________ **ID: G**__________ **SS#:** __________

Address:____________________________ **City:**__________ **Zip:** __________

Date of Birth:________________ **Age:**______ **Cell #** ______________________

Consent: I hereby give my permission to be seen by the SHC Health Professionals. I have read, or had explained to me, the information about the immunization and tuberculosis screening necessary for me to participate in above academic program.

Signature: **Date:**

IVC NURSE USE ONLY!!

IMMUNIZATION REQUIREMENT: ATTACH IZ RECORD & TEST RESULTS

Required Immunization/Test	**Date done/Results**	**Required Immunization**	
☐ PPD step 1 (Yearly) ☐ PPD step 2	1. Date Given: ___/___/___ Date Read: ___/___/___ ☐ Neg. ☐ Pos. 2. Date Given: ___/___/___ Date Read: ___/___/___ ☐ Neg. ☐ Pos.	Varicella (chicken pox) 1. ___/___/___ 2. ___/___/___ Titer ___/___/___ ☐ Neg. ☐ Pos.	☐ Had disease ☐ Yes, script given ☐ No, script not given
If positive, Q-Gold Chest x-ray	1. ___/___/___ ☐ Neg. ☐ Pos. 1. ___/___/___ ☐ Neg. ☐ Pos.	Hepatitis B (3 doses) 1. ___/___/___ 2. ___/___/___ 3. ___/___/___ Titer ___/___/___ ☐ Neg. ☐ Pos.	☐ Yes, script given ☐ No, script not given
☐ Tdap (Every 10 years)	1. ___/___/___		
MMR (2 doses) Titer	1. ___/___/___ 2. ___/___/___ 1. ___/___/___ ☐ Neg. ☐ Pos.		
Flu (attach consent/decline form)	1. ___/___/___	**Note:**	

IVC SHC NURSE PRACTITIONER USE ONLY!!

EXAMINATION:

Height:________ inches Weight: ________ lbs. BMI:

Blood Pressure: ________ Pulse: ________ Repeat BP: ________ Pulse:

Vision: R: ________ L: ________ ☐ with ☐ without glasses / contact lenses

Area	Normal	Abnormal Findings
Vital signs		
Skin		

Lymphatic		
Head		
Ears		
Eyes		
Nose		
Mouth /throat		
Neck		
Back and spine		
Shoulders		
Upper extremities		
Heart		
Lungs		
Abdomen		
Gastrointestinal		
Lower extremities		
Other		

Comments and General Health Recommendations:

☐ ABLE TO LIFT 35 LBS.

__________ Cleared

I certify that as the health examiner, I have completed the appraisal on the above student, and affirm that this person is free of disease to perform assigned program duties and do not have any health condition that would create a hazard for himself/herself, fellow classmates, patients or visitors.

Provider Date

Cleared with the following recommendations

☐ ABLE TO LIFT 35 LBS.

I have been informed of the above recommendations and given education materials on:

☐ Hypertension ☐ Diabetes Mellitus ☐ Diet ☐ Exercise ☐ Vision problems

I also received copy of my History, Physical, and TB Screening forms.

Student (Print Name): __________________________________

Signature: ________________________________ Date: ____________________

____________________________________ LVN ___________________________ Access File