# 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:**

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## IVC NURSE USE ONLY!!

## IMMUNIZATION REQUIREMENT: ATTACH IZ RECORD & TEST RESULTS

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

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## 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