COLLIN COLLEGE

IMMUNIZATION RECORD and PHYSICAL EXAM FORM

Date:_____

CWID# _____

Name:_____ Birth Date:_____
Last First Middle

Address: _____
Street City State Zip

Phone: _____ _____ _____
Home Work Cell

Health Questionnaire: To be completed by the student

Do you have any physical limitations that would affect your ability to lift, turn, or transfer patients? ☐ Yes ☐ No

Do you have any limitations in use of your senses, such as in sight or hearing that would limit your ability to practice a health profession? ☐ Yes ☐ No

Do you have any condition that might interfere with your ability to practice a health profession? ☐ Yes ☐ No

If you answered "yes" to any of the above, please explain your limitations in detail on a separate sheet of paper.

I_____, certify that the information above is accurate and true.
Name

PHYSICAL EXAMINATION: To be completed by licensed health care provider (MD, PA, NP).

Student Name: _____ Date: _____

Height_____ Weight_____ Temp_____ Blood Pressure_____ Sex F M

Vision_____ Glasses_____ Contact Lenses: R_____ L_____

History: Include any significant information regarding previous medical and surgical conditions and use of alcohol and/or drugs.

1. Based upon your physical examination, is the applicant free of any restrictions in his/her ability to turn and/or move heavy objects. If "no" please describe. ☐ Yes ☐ No

2. Is the applicant able to see and hear adequately to practice a health care profession? If "no", please explain. ☐ Yes ☐ No

3. Is the applicant free of any pathological conditions either physical or mental, which would interfere with the practice of a health profession? ☐ Yes ☐ No

_____ _____
Signature of Health Care Provider Address of Health Care Provider

Please provide documentation of the following immunizations:

1. **Tuberculosis Screening.**
   Test is required annually and must be current throughout the program and each clinical rotation.
   Quantiferon Gold TB blood test every 12 months.

   ☐ Chest x-ray is required every five years - if you have had a positive TB test (PPD or Quantiferon)
   ☐ Provide documentation of the positive test as well as your x-ray documentation (free from disease).
   A clear Chest X-ray alone is not acceptable.

2. **MMR (Measles/Mumps/Rubella) – Blood titer ONLY**
   You must have 2 MMR doses or confirmation of immunity titer. You must provide the actual lab that illustrates positive immunity.

3. **Varicella – Blood titer ONLY**
   You must have 2 vaccinations or confirmation of immunity titer. You must provide the actual lab that illustrates positive immunity.

4. **Hepatitis B – Blood titer ONLY**
   You must have 3 vaccinations or confirmation of immunity titer. You must provide the actual lab that illustrates positive immunity.

5. **Tdap.**
   You must provide documentation of immunization every 10 years. Note: This is NOT Td or DTap.

6. **Influenza.**
   Required during flu season—usually September to April

<u>Immunizations must NOT expire during a clinical semester.</u>

*****Vaccine records from a physician's office must be signed by the health care provider or the person who administered the vaccine and must indicate the date given for each vaccine. (example is childhood immunization records). We will not accept childhood immunization records with only dates written in beside the vaccine. When in doubt, get a titer drawn.**

*****Vaccines administered at a clinic must include the date of administration, lot number, and signature of who administered the vaccine.**

We will NOT accept the following:

- **School of nursing or grade school immunization form even if signed by a health care provider**
- **University health record**
- **A cash receipt for a vaccination**