SOUTHEAST Technical College

PHYSICAL / IMMUNIZATION FORM

This form is required to be completely filled out by a primary care provider and returned to Southeast Technical College within ONE YEAR PRIOR to the start of any Healthcare program and within ONE YEAR PRIOR to attending clinical or internships. Students are responsible for returning all forms to Southeast Technical College's Health Programs Administrative Assistant.

General Information

Southeast Tech Program: _____

Full Name (First, Middle, Last): _____

Last 4 Digits of Social Security Number: _____ Student ID #: _____ Gender: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone: _____ Mobile: _____

Insurance Company: _____

Policy No.: _____

Please attach a photocopy of both sides of the insurance card.

Allergies

Is the student allergic to or has had adverse reaction to anything such as medications, foods, latex, plants, insects, animals, etc.? If yes, please explain.

Allergic to	Reaction

Latex Advisory

In addition, the individual has been advised of exposure to latex and latex-based products in healthcare environments and the potential health risks for individuals with sensitivities or allergies.

INITIAL HERE: _____

Medications

List all medications currently used, including any over-the-counter medications.

☐ CHECK BOX IF NO MEDICATIONS ARE ROUTINELY TAKEN.

Medication	Dose	Frequency	Reason

IF ADDITIONAL SPACE IS NEEDED, PLEASE INDICATE ON A SEPARATE SHEET AND ATTACH IT.

Health History

Does the student currently have or has ever been treated for any of the following?

Yes	No	Condition	Yes	No	Condition
		Diabetes			Thyroid disease
		Head injury/concussion			Hernia
		Chronic cough			Urticaria
		Tuberculosis			Varicose veins
		Fainting spells and dizziness			Drug addiction
		Asthma			Alcoholism
		Weak back/back surgery			Fallen arches
		COPD			Excessive fatigue
		Ears/eyes/nose/sinus problems			Seizure disorders
		Psychiatric/psychological or emotional difficulties			Hypertension (High blood Pressure)
		Behavioral/neurological disorders			Abdominal/stomach/digestive problems
List any other medical conditions not covered above, and/or provide information concerning any boxes checked "yes."					

Physical Examination

Date of Examination _____

A physical examination is important for students enrolled in Healthcare programs to provide evidence that they can meet the demands of their profession without hazard to themselves and others.

DOB: _____ Age: _____ Height (inches): _____ Weight (lbs.): _____

T/P/R: _____ /_____ /_____ BP: _____ /_____ Color Blindness: **Y** or **N** (circle one)

Vision acuity: _____ Vision with correction (eye glasses or contacts): 20/_____ (L) 20/_____ (R)

HEENT: _____ Hearing Assessment: _____

Cardiopulmonary: _____ Neurological: _____

Abdominal: _____ Musculoskeletal: _____

Back: _____ Rectal/GU: _____

List any physical limitations noted:

Immunization Requirements

MMR (Measles, Mumps, Rubella)

Immunization Date(s)			Titers	

Complete ONE of the following:
- Two doses of MMR vaccine.
- MMR titer showing immunity, or a statement signed by a medical provider licensed to practice medicine or health authority affirming serologic evidence.

Varicella (Chickenpox)

Immunization Date(s)			Titers	

Complete ONE of the following:
- Two doses of Varicella vaccine.
- Proof of an adequate Varicella titer.

Hepatitis B

Immunization Date(s)			Titers	

Complete ONE of the following:
- Three doses of Hepatitis B vaccine at appropriate interval between shots.
- Two doses ONLY if receiving Heplisav-B (HepB-CpG), manufactured by Dynavax, which is approved for two doses, one month apart.
- A statement signed by a medical provider licensed to practice medicine or health authority affirming serologic evidence of immunity to Hepatitis B.

Tetanus, Diphtheria and Pertussis (Tdap)

Immunization Date(s)				

Complete ONE of the following:
- One dose of Tdap vaccine within the last 10 years.
- A statement signed by a medical provider licensed to practice medicine or health authority affirming serologic evidence of immunity to Tetanus and Diphtheria.

Flu (To be completed for each flu season while an active student.)

Immunization Date(s)				

Tuberculosis (TB)

Date(s)				
Given:	**Read:**	**Results:**	QuantiFERON TB results	
Given:	**Read:**	**Results:**		

Complete ONE of the following:
- Proof of a negative two-step TB skin test (The two-step process requires a one-week interval between shots, not to exceed 28 calendar days.)
- One TB skin test if performed annually (Must provide physical documentation of annual tests.)
- QuantiFERON TB Gold blood draw.
- If positive TB – Documentation of treatment and proof of inactive status. If known converter, chest x-ray less than 12 months old upon entry into clinical with completion of a Center for Disease Control (CDC) TB questionnaire annually thereafter.

COVID-19

COVID-19 Vaccination Brand	COVID-19 1st Dose	COVID-19 2nd Dose (if Applicable)
COVID-19 Booster Brand	**Booster Date**	**Booster Date**

- If not fully vaccinated, an exemption request must be made through myTech.
- Weekly testing, additional Personal Protective Equipment (PPE) and paperwork may be required before scheduling and attending clinical.

If a student has a medical exemption to immunization, a medical provider licensed to practice medicine must certify that the immunization is detrimental to the student's health. The medical exemption should specify which immunization is detrimental to the student's health, provide information as to why the immunization is contraindicated based on current accepted medical practice, and specify the length of time the immunization is medically contraindicated, if known. Please use the space below to specify. Please be advised, even with a medical exemption, students still may not be able to attend clinicals at certain facilities.

The below should be completed by the Primary Care Provider (the person completing this form).

By signing this form, I verify that I have reviewed the information on this form, including medical diagnoses (if any) and medications (if any) and found that, (student name)_____ has no health restrictions and may participate in the _____ program at Southeast Tech.

☐ Check box if you would recommend re-evaluation for a change of health program.

Date of Exam: _____

Printed examiner's name: _____

Examiner's signature: _____

Credentials: _____

Southeast Tech Students:

Return this completed form to the Health Records office, located in the Sullivan Health Science Center, Office HC 200 or scan and email form to health.records@southeasttech.edu or fax 605-367-6108.
It is the student's responsibility to be sure all forms have been received.

Other Requirements:

- Basic Life Support and CPR Card through the American Heart Association or American Red Cross Health Programs

Updated: April 5, 2024