

**QUINSIGAMOND COMMUNITY COLLEGE  
HEALTH CARE PROGRAMS  
PHYSICAL EXAM, TESTING, REQUIRED IMMUNIZATIONS AND TITERS FOR CLINICAL  
PLACEMENT**

**STUDENT INFORMATION**

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Last name	First	Middle	Maiden Name
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Current Address: Street Name and Number	Apartment or Building Number
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City	State	Zip Code	Telephone Number
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Date of Birth	Age	Sex
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Name of Person to be Notified in Case of Emergency	Relationship
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Address of Person to be Notified in Case of Emergency	Telephone Number
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Student Signature	Date
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**PHYSICAL EXAMINATION**

**PHYSICAL EXAMINATION TO BE COMPLETED BY A PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT**

**ALL** information including completion of this form must be satisfactorily completed and received prior to the first day of class. The information is solely for the use of the College staff and will not be released without the student's permission. Clinical sites will be notified that the student has met all the medical and immunization requirements. **Physical Exam must be within one-year of program start date.**

Date of Physical Exam: \_\_\_\_\_

MD signature: \_\_\_\_\_

**Date:** \_\_\_\_\_

Print name: \_\_\_\_\_

Address: \_\_\_\_\_

**Note: Health Care Provider must sign and date both sides of this form**

NP or PA signature: \_\_\_\_\_

**Date:** \_\_\_\_\_

Print name: \_\_\_\_\_

Address: \_\_\_\_\_

**PLEASE TURN OVER FOR REQUIRED TESTING, IMMUNIZATIONS AND TITERS FOR HEALTH CAREER STUDENTS**

## REQUIRED TESTING, IMMUNIZATIONS AND TITERS FOR HEALTH CAREER STUDENTS

Student Name: \_\_\_\_\_ QCC ID#: \_\_\_\_\_

### DIPHTHERIA AND TETANUS

	<b>Date of last dose</b>	<b>Within last 10 years</b>
Td		<b>YES or NO</b>

### HEPATITIS B

	<b>Vaccine # 1</b>	<b>Vaccine # 2</b>	<b>Vaccine # 3</b>	<b>Or Titer Result</b>
<b>HEPATITIS B</b>				

### INFLUENZA VACCINE (Nursing students only)

	<b>Date</b>
<b>INFLUENZA VACCINE</b>	

### MANTOUX - TUBERCULOSIS- (Center for Disease Control Requirement)

2 STEP TB is done once and then single TB annually. (Must have been administered at least 1 week apart and less than a year apart and within 6 months of program entry)

	<b>Date Implanted</b>	<b>Date Read</b>	<b>Result</b>	<b>Over 12 months</b>
<b>#1 IMPLANTED</b>				
<b>#2 IMPLANTED</b>				
<b>CHEST X-RAY</b>				
If applicable, current and/or proposed treatment:				

### DISEASE IMMUNITY: (Please read carefully)

Documented proof of immunity is required for the **ALL** communicable diseases listed in the table below. Documentation of vaccination or titer is acceptable for measles (rubeola), mumps, and rubella. A varicella titer is required.

<b>MEASLES , MUMPS, AND RUBELLA VACCINE</b>	<b>Date:</b>
<b>MEASLES BOOSTER OR</b>	<b>Date:</b>
<b>MEASLES TITER</b>	<b>Results:</b>
<b>VARICELLA TITER</b>	<b>Results:</b>

MD, NP, or PA Signature \_\_\_\_\_ Date \_\_\_\_\_

<i>For QCC Use only</i>	SORI form received	YES	NO	Initials: _____
	CORI form received	YES	NO	Initials: _____
<b>Copies of current healthcare related cards on file with Clinical or Program Coordinator</b> (Examples include but not limited to CPR, Health Insurance verification, EMT, etc)		YES	NO	Initials: _____
<b>This QCC Student has met the requirements to enter an Affiliated Clinical Site</b> <i>Updated 4.6.09</i>		YES	NO	Signed: _____