

# Health Sciences Program Physical Exam & Immunization Form

## Student Information

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

Student ID: \_\_\_\_\_

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First

\_\_\_\_\_  
M Maiden/Other name

\_\_\_\_\_  
Phone#

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Health Program

\_\_\_\_\_  
Signature

(By signing this, I give permission for CCCC to release my immunization information to clinical agencies)

## PHYSICAL EXAMINATION

### TO BE COMPLETED BY A HEALTHCARE PROVIDER

All health information requested on this form must be satisfactorily completed and received by the program's deadline date.

#### PHYSICAL EXAM

Physical exam must be within one year of program start date.

**Date of Physical Exam:**    /    /

\_\_\_\_\_  
Healthcare Provider Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Primary Phone Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

Name: \_\_\_\_\_ ID: \_\_\_\_\_

**REQUIRED TESTING, IMMUNIZATIONS, AND TITRES FOR HEALTH SCIENCE STUDENTS**

**Disease Immunity: (Please read carefully) Documented proof of immunity is required.**

Immunization	Date Administered
Tdap (tetanus/diphtheria/pertussis) 1 adult dose	
Td (tetanus/diphtheria) if more than 10 years since Tdap	

Immunization	Date Administered
MMR#1 (Measles, Mumps & Rubella)	
MMR#2 (Measles, Mumps & Rubella)	
Varicella Vaccine (chicken pox) #1	
Varicella Vaccine (chicken pox) #2	

**or**

Immunity Titres Healthcare providers must record results of titres for the diseases listed below and <b>submit copy of lab report</b>	Date Administered	Results
Positive Measles Antibody IgG titre		
Positive Mumps Antibody IgG titre		
Positive Rubella Antibody IgG titre		
Positive Varicella (chicken pox) Antibody IgG titre		

Tuberculosis Skin Testing required	Plant Date	Read Date	Results
TB Skin test (PPD) #1			
TB Skin Test (PPD) #2 (if required)			

**or**

Tuberculosis Testing Submit Copy of Lab Report	Date Administered	Results
QuantiFeron® (TB blood t est) annually		
T-Spot® (TB blood t est) annually		
Chest X-ray <b>within 2-years</b> after positive TB skin test and Non-symptom TB Questionnaire <b>(annually)</b>		

**Healthcare Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Name: \_\_\_\_\_ ID: \_\_\_\_\_

**REQUIRED TESTING, IMMUNIZATIONS, AND TITRES FOR HEALTH SCIENCE STUDENTS**

**Disease Immunity: (Please read carefully) Documented proof of immunity is required.**

Influenza Vaccine	Date Administered
Influenza vaccine (upcoming Fall season)	

Up to date Covid-19 vaccine compliancy may be required to meet clinical placement.	Manufacturer	Date Administered
COVID-19 Vaccine		

Hepatitis B Vaccines	Date Administered	Manufacturer
Hepatitis B vaccine		
Hepatitis B vaccine		
Hepatitis B vaccine		
**EVERY STUDENT MUST TEST AND SUBMIT AN IMMUNE HEP B SURFACE ANTIBODY TITRE	Date Administered	Results
Hepatitis B surface antibody titre of immunity		

If you have **NO RECORD** of a previous Hepatitis B vaccine series please complete the **Heplisav-B 2-dose** series and then test for immunity 1-2 months later.

Advisory Committee on Immunization Practices (ACIP) recommends that healthcare personnel with written documentation of having received a properly spaced series of hepatitis B vaccine in the past (such as in infancy or adolescence) but who now test negative for anti-HBs should receive a single “challenge” dose of hepatitis B vaccine and be retested 1-2 months later. Those who test positive following the “challenge” dose are immune and require no further vaccination or testing. Those who test negative should complete a second series of hepatitis B vaccine on the usual schedule and be tested again 1-2 months after the last dose. Heplisav-B may be used to revaccinate new healthcare personnel (including the challenge dose) initially vaccinated with a vaccine from a different manufacturer in the past who have anti-HBs less than 10 mIU/mL upon hire or matriculation.

**Heplisav-B** is approved as a 2-dose schedule for persons age 18 years and older, including healthcare professionals. The doses should be separated by at least 4 weeks. Ask your healthcare provider for details.

**Healthcare Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**All health science students send health forms to:**

Student Immunization Records  
 2240 Iyannough Road | West Barnstable, MA 02668  
 Email: [immunizations@capecod.edu](mailto:immunizations@capecod.edu)  
 Fax: 508-375-4039

**Immunization Questions?** Call 774.330.4331.

The Student Records Immunization Office is in the lower level of the Nickerson Administration building.