INSTITUTE OF AMERICAN INDIAN ARTS

GENERAL PHYSICAL EXAMINATION AND LABORATORY TESTS

THIS FORM MUST BE COMPLETED BY A PHYSICAN OR MEDICAL PROVIDER

NAME OF STUDENT:_____

Note: ALL ITEMS ARE REQUIRED. Please indicate all findings, normal as well as abnormal.

- Allergies: Indicate if patient has allergies to medications and document the nature of the reaction.
- Conduct the physical exam. Comment on any abnormal findings and indicate what treatment if any was provided.
- Obtain blood pressure, pulse, height and weight.
- Indicate if student is receiving care for a chronic illness or treatment for an emotional disorder.
- Perform the required tests indicating date of test and results.
- The PPD skin test must be placed and read before the student will be allowed to move into campus housing. **NOTE: If PPD is greater that 10mm induration, a chest x-ray must be obtained. If the chest x-ray is abnormal, INH treatment or other TB prophylaxis should be initiated.**
- Physician or medical provider should provide signatures and office stamp verifying completion of exam.

ALLERGIES: ☐Yes ☐No. If yes, to what? ☐PCN ☐Sulfa ☐Erythromycin Other_____

If yes, what is the nature of the reaction?_____

Is this individual currently on any medications? If yes, please list all medicine(s) by name, dosage and purpose of medication

_____

_____

	Normal	***Abnormal***	***Comments (all abnormal findings)***
Head and Neck	☐	☐	_____
Cardiovascular	☐	☐	_____
Abdominal	☐	☐	_____
Neurological	☐	☐	_____
Extremities	☐	☐	_____
Surgeries/date	☐	☐	_____
Skin	☐	☐	_____
Respiratory	☐	☐	_____
ENT	☐	☐	_____

Blood Pressure_____Pulse_____Height_____Weight_____

Is this individual under care for a chronic or serious illness? ☐ Yes ☐ No If yes, please explain_____

_____

REQUIRED TESTS

	Date	**Results**
Urinalysis	_____	_____
HGB/HMCT	_____	_____
PPD*	_____	_____

***NOTE: PPD test should be mantoux within the past year (tine or momovac not acceptable). PPD must be placed and read before student will be allowed to move into campus housing. Treatment should be initiated if positive, greater than 10 mm induration and chest x-ray is abnormal.** If positive, provide_____mm indurations (horizontal diameter).

Note: If greater than 10mm induration, chest X-ray required.
X-Ray results: ☐Normal ☐Abnormal

If chest x-ray is abnormal, has patient begun INH treatment or other TB prophylaxis treatment? ☐Yes ☐No If no, please explain

_____

Received BCG: ☐ **Yes** ☐ **No** If yes, chest X-Ray required. X-Ray results: ☐ **Normal** ☐ **Abnormal**

PHYSICIAN OR MEDICAL PROVIDER SIGNATURE

Physician/PA/NP_____
Name (Please Print) Signature

ADDRESS_____
Number and Street City State Zip

Telephone Number (include area code)_____ Date Exam Completed_____

IMMUNIZATION RECORD

NAME OF STUDENT_____

Please note: All immunizations and/or lab serology tests are required unless otherwise noted. This record must be completed by your physician or medical provider. All immunizations must be verified by the signature and office stamp of your physician or medical provider below. You may submit copies of immunization records and lab/serology test as proof of vaccine, history of disease or immunity.

Please make copies of this record for your personal records

	REQUIRED VACCINES	**MONTH/DAY/YEAR**
A.	**MENACTRA VACCINE A/C/Y/3-135 (REQUIRED)** **VACCINE AGAINST NEISERRIA MENINGITIS**	_____/____/_____
B.	**VARICELLA VACCINE (2 doses required)** **VACCINE AGAINST CHICKENPOX DISEASE**	
	☐ First vaccine (Required)	_____/____/_____
	☐ Second vaccine (Required: due 4 weeks after first vaccine)	_____/____/_____
	Other Means of Obtaining Proof of Immunity	
	☐ Student had disease (chickenpox or shingles confirmed by MD's records)	_____/____/_____
	☐ Laboratory/serology test for evidence of immunity:	_____/____/_____
	(Obtain if uncertain about dates of vaccine disease)	☐**Reactive** ☐**Non-reactive**
	Note: If the test is NON-REACTIVE, you MUST receive the Varicella vaccines	
C.	**HEPATITIS VACCINE (3 doses required)** **VACCINE AGAINST HEPATITIS B DISEASE**	
	☐ First vaccine	_____/____/_____
	☐ Second vaccine (due 4 weeks after first vaccine)	_____/____/_____
	☐ Third vaccine (due 6 months after second vaccine)	_____/____/_____
	Other Means of Obtaining Proof of Immunity	
	☐ Laboratory/serology test for Hepatitis B surface antigen antibody:	_____/____/_____
	(Obtain if uncertain about dates of your Hepatitis B vaccines)	☐**Reactive** ☐**Non-reactive**
	Note: If the test is NON-REACTIVE, you MUST receive the Hepatitis B vaccines.	
D.	**M.M.R. (2 doses required)** **VACCINE AGAINST MEASLES, MUMPS AND RUBELLA**	
	☐ First vaccine should be given 12-15 months	_____/____/_____
	☐ Second vaccine should be given 4-6 years or after	_____/____/_____
	☐ Student born before 1957 is considered immune. **<Date of Birth>**	_____/____/_____
	Other Means of Obtaining Proof of Immunity	
	☐ Laboratory/serology test for evidence of immunity:	_____/____/_____
	(Obtain if uncertain about dates of vaccine or disease)	
	Note: If the test is NON-REACTIVE, you MUST receive the MMR vaccines.	
E	**TETANUS, DIPHTHERIA (Tdap) or (Td)** **VACCINE TO PREVENT "LOCKJAW"**	_____/____/_____
	Tetanus/diphtheria containing booster dose within the last 10 years.	

HEALTH CARE PROVIDER
Please stamp with office stamp to verify you have reviewed and/or administered any or all immunizations
(Office Stamp Here)

Provider_____
Name (please print) Signature and Title