Student's Name _____

IC ID Number _____

ILLINOIS COLLEGE
JACKSONVILLE, IL

IMMUNIZATION RECORD

Please give this form to your physician, nurse practitioner or physician's assistant.

As of July 1989, all students born after January 1, 1957 registering for the first time at public or private colleges in Illinois must present evidence of immunity against the vaccine-preventable diseases. **If no proof of immunization, certification of medical exemption, or statement of religious objection is presented, the student will not be permitted to register for courses** (Public Act 85-1315). *Required for entrance.

TO THE EXAMINING PROVIDER: Please complete and sign the Immunization Record. This information is necessary for the College to best serve the student. ❑ Check here to see attached immunization records.

TO RETURN THIS FORM, SCAN AND UPLOAD IT AT LOGIN.IC.EDU IN THE MEDICAT APP.

Should you have any questions, contact us at 217.245.3038.

Student's Name _____ DOB_____ ❑ Male ❑ Female ❑ Transgender

Measurements:

Temp _____ Pulse _____ Resp _____ BP _____ Height _____ cms/inches Weight _____ kgs/lbs BMI _____

Visual Acuity: Uncorrected [ ] Right 20/ _____ Left 20/ _____ Corrected [ ] Right 20/ _____ Left 20/ _____

ATHLETES ONLY: Which sport? _____ Do you have sickle cell trait/disease*? ❑ Yes ❑ No (attach documentation)

**The NCAA mandates that all student athletes must submit their sickle cell results before any participation in intercollegiate sports. We are able to accept results from birth or new test results.*

ARE THERE ANY ABNORMALITIES OF THE FOLLOWING SYSTEMS? Please describe fully. Use additional sheet if needed.

	Normal	Abnormal	Not Examined	Comments
General Appearance: Marfan stigmata, LOC, nutrition, development, mobility, affect, speech, hygiene				
Skin: rash, HSV, lesions suggestive of MRSA, color, tinea corporis, acne				
Head: shape, size, symmetry, scalp, TMJ, lesions, hair				
Eyes: Lids, conjunctiva, sclera				
Extraocular muscles				
Visual fields				
Pupils: size, reaction to light and accommodation				
Fundi				
Ears: pinna, canals, TMs, hearing				
Nose: patency, nares, sinuses, nasal mucosa, septum, turbinates				
Mouth: lips, gums, teeth, mucosa, palate, tongue				
Throat: pharynx, tonsils, uvula				
Neck: ROM, symmetry, palpation, thyroid, lymph nodes				
Breasts: size, symmetry, skin, nipples, palpation, nodes				
Chest/Lung: excursion, palpation, percussion, auscultation				
Cardiac: PMI, palpation, rate, rhythm, S1, S2, murmurs (standing, supine, +/- Valsalva), gallops, bruits, extra sounds				
Abdomen: appearance, bowel sounds, bruits, percussion, palpation, liver, spleen, flank, suprapubic, hernia				
Anorectal: perianal, digital rectal, stool guaiac				
Female Genitalia: Internal: vaginal mucosal, cervix				

Bimanual: vagina, cervix, uterus, adnexa				
Male Genitalia: penis, scrotum, testes, hernia				
Lymph Nodes: cervical, subclavian, axillary, inguinal, other				
Musculoskeletal: Back/Spine: ROM, palpation				
Upper Extremity: ROM, strength, palpation of shoulder/arm/elbow/ forearm/wrist/hand/fingers				
Lower Extremity: ROM, strength, palpation of hip/thigh/knee/leg/ankle/ foot/toes				
Functional: Duck-walk, single leg hop				
Peripheral Vascular: Upper Extremity: pulses, appearance, temp				
Lower Extremity: pulses, appearance, temp, simultaneious femoral and radial pulses				
Neurologic: cranial nerves, motor, sensory, cerebellar, reflexes, gait, mental status				

ASSESSMENT:

On the basis of this examination, I approve the student's participation in:

❑ Any intercollegiate sports for one year ❑ Yes ❑ No ❑ Limited

❑ Any physical education activity class with no restrictions

❑ An adapted physical education program to exclude the following activities: _____

❑ No physical education activity classes for the following reason(s): _____

TUBERCULOSIS (TB) SCREENING/TESTING

Please answer the following questions:

Have you ever had a positive TB skin test? ❑ Yes ❑ No

Have you ever been vaccinated with BCG? ❑ Yes ❑ No

Have you ever had close contact with persons known or suspected to have active TB disease? ❑ Yes ❑ No

Were you born or have lived outside of the U.S.? ❑ Yes ❑ No If yes, what country: _____

If the answer to any of these questions is yes, a Tuberculin Skin Test is required.

Tuberculin Skin Test Date given: ____/____/____ Date read: ____/____/____

Result:_____ (record actual mm of induration, transverse diameter; if no induration, write "0")

Interpretation (based on mm of induration as well as risk factors): ❑ Positive ❑ Negative

Interferon Gamma Release Assay (IGRA) Date Obtained: ____/____/____

(specify method) ❑ QFT-GIT ❑ T-Spot ❑ other

Result: ❑ Negative ❑ Positive ❑ Indeterminate ❑ Borderline (T-Spot only)

Chest X-ray (required if TST or IGRA or T-Spot is positive) Result: ❑ Normal ❑ Abnormal Date of chest x-ray: ____/____/____

HEALTH CARE PROVIDER CERTIFICATION

Health Care Provider (please print) _____

Health Care Provider's Signature _____ Date _____

Address _____

Telephone _____ Fax _____

ILLINOIS COLLEGE

Chelsey Health and Wellness Center
1101 West College Avenue :: Jacksonville, Illinois 62650
217.245.3038 :: Fax 217.245.3039