Robert Morris University (RMU)
School of Nursing and Health Sciences
ANNUAL HEALTH EVALUATION FORM

Student Name: ____

Address: ____

Phone Number: ____

Instructions for Completion of the Annual Health Evaluation Form for the Nursing Program

Directions for the Healthcare Provider (Physician, Nurse Practitioner, Physician Assistant)

- Perform a health history and a physical exam.
- Fill out the health evaluation form completely, recording all required information directly onto this form.
- Attachments, such as lab reports, copies of immunization records, etc., are required as indicated on this form.
- Immunizations are to be up-to-date as recommended by the CDC.
- Required annual One-Step PPD is Mantoux type and is considered valid for one year.
- Alternative testing for TB is a QuantiFERON Gold blood test.
- Signature of Healthcare Provider with the date of the exam is required on this form.

Directions for the RMU Nursing Student

- The nursing student is responsible for the health form being completed fully as required.
- Complete up-to-date health evaluations are an ongoing requirement for attendance at clinical.
- The nursing student must sign and date the “Clinical Agency Permission.”
- The nursing student must sign and date the “Student’s Health Insurance Agreement.” A copy of the health insurance card (front and back) is also to be submitted.
- Questions about submitting/uploading requirements to Certified Background Check should be directed to Student Support at 888-666-7788 or to studentservices@certifiedprofile.com.

Annual Health Evaluation Form: RMU Nursing Program

Student Name: (please print) ____

SINGLE-STEP PPD (TB Testing)	
Date of administration: _____/_____/_____	**Date read:** _____/_____/_____
Administered by: ___________________________	**Read by:**___________________________
Lot #_______________**Exp. Date:**______________	**Results:** ______**Negative** or ______**Positive**
Results in millimeters must be given: ___________________________________**mm**	

*******OR*******

Quantiferon Gold Blood Test: Lab Report Documentation Required	
Date: ________/__________/_________	**Result of Quantiferon Gold Blood Test:** ___________**Negative** or ___________**Positive** **May provide documentation with lab report**

<u>If either PPD Testing or Quantiferon Gold Blood Test is positive for TB:</u>

Chest x-ray Date:____________________________

Results: _____ **Normal** ____ **Abnormal** **Treated for positive PPD:** ____ **Yes** ____ **No**

Treatment:_____________________ **Start Date:**_____________**Duration:**__________________

Hepatitis B Series Update	
□ **Immunization series complete**	**Date Completed**: ____________________________________
□ **Immunization series in progress**	**Date(s)** :____
□ **Immunity by Titer**	**Date of Titer**: ____
□ **Non-Immunity by Titer**	**Date of Titer:**____
□ **Second series for Hepatitis B required with non-immunity result by titer**	**Date(s):** ______/______/______ ______/______/______ ______/______/______

Annual Health Evaluation Form: RMU Nursing Program

Student Name: (please print) ____

1. I have obtained a health history and performed a physical exam. If no, please explain.

____ Yes ____ No

____

2. In my opinion, based on my assessment, the student has no cognitive, sensory, psychological or physical limitations (vision, hearing, speech, touch, smell, reading/language, writing, movement, lifting) that would prevent him/her from fully participating in the Department of Nursing Program, or providing safe nursing care. If no, please explain.

____ Yes ____ No

____

Name (Please Print) ______________________________ MD/DO/CRNP/PA (Circle)

Address____

Phone_________________________________ Fax________________________

Signature_______________________________ Date______________________

Annual Health Evaluation Form: RMU Nursing Program

Student Name: (please print) ____

Completion by Student Nurse in the RMU Nursing Program

Clinical Agency Permission: (Check mark, sign, and date)

____ I give permission to release my medical information to the course-related clinical agencies.

I hereby release the clinical agency, Robert Morris University and their respective agents, officers, trustees, directors and employees from any and all claims, including but not limited to, claims of defamation, invasion of privacy, wrongful dismissal, negligence, or any other damages resulting from or pertaining to the collection, dissemination or use of this information.

Signature of Student: ______________________________ Date: ____________________

Student's Health Insurance Agreement: (Sign and date)

I verify that I am covered by health insurance. I agree to maintain health insurance coverage throughout the nursing program which includes, but is not limited to, payment for treatment and follow-up procedures, including exposure to blood-borne pathogens as well as other potentially infectious materials. I include a copy of the health insurance card (front and back) as required.

Signature of Student: ______________________________ Date: ____________________

It is the ongoing responsibility of the student to inform the Robert Morris University Department Head of Nursing of any significant changes in his or her health status.

Academic action may include removal from clinical and/or course/clinical failure if there has been deliberate misrepresentation of information in any manner on this health form.

Revised: 10/2008
Revised 2/2013