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

Student Name: _____

Address: _____

Phone Number: _____

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

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

- Perform a health history and a complete 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.
- Titers are required as indicated on the form.
- Initial required PPD is a Two-Step; a One-Step PPD is then required annually.
- Signature of the 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 with annual health updates necessary.
- 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 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.

Initial Health Evaluation Form: RMU Nursing Program

Student Name: (please print) _____

RECORD OF IMMUNIZATIONS

Immunization	Completed Series		Dates
TDaP/TD	□ Yes □ No	**TDap (<u>required</u>) within last 10 years:**	Date: ____/_____/_____
Varicella ***Series in process is <u>not</u> acceptable***	□ Yes □ No □ History of disease	**Booster:** □ Yes □ No	Date(s) of immunization: ____/_____/_____ ____/_____/_____
MMR ***Series in process is <u>not</u> acceptable***	□ Yes □ No □ History of disease		Date(s): _____/_____/_____ _____/_____/_____
Hepatitis B ***Series in process is acceptable***	□ Yes □ No		Date(s): _____/_____/_____ _____/_____/_____ _____/_____/_____

REQUIRED TITERS AND LAB REPORT DOCUMENTATION

Date of Titer	Titer Results/ Test Interpretation	Recommendation
Rubeola (Measles) ***Titer Required*** Date of Titer: _____/_____/_____	□ Immune □ Non-Immune	**The student should obtain a copy of the lab report for his or her records.**
Mumps ***Titer Required*** Date of Titer: _____/_____/_____	□ Immune □ Non-Immune	**The student should obtain a copy of the lab report for his or her records.**
Rubella (German Measles) ***Titer Required*** Date of Titer: _____/_____/_____	□ Immune □ Non-Immune	**The student should obtain a copy of the lab report for his or her records.**
Varicella (Chicken Pox) ***Titer Required*** Date of Titer: _____/_____/_____	□ Immune □ Non-Immune	**The student should obtain a copy of the lab report for his or her records.**
Hepatitis B Titer Required **<u>if</u> series of 3 vaccinations are not documented by immunization dates on this form** Date of Titer: _____/_____/_____	□ Immune □ Non-Immune	**The student should obtain a copy of the lab report for his or her records.**

Initial Health Evaluation Form: RMU Nursing Program

Student Name: (please print) _____

History of prior reaction to Two-Step PPD (Mantoux) Test: Yes _____ No_____

<u>If yes</u>, was a screening for signs and symptoms of Tuberculosis completed? Yes_____ No_____

<u>If positive</u>, date of last chest x-ray: _____ _____

X-Ray Results:_____

Treatment: _____

Two-Step PPD (TB Testing)

<u>Step One of Two-Step</u>

Administration **Interpretation (Read in 48-72 Hours)**

Date of administration: _____/_____/_____ **Date read: _____/_____/_____**

Lot #_____Exp. Date:_____ **Result: _____Negative or _____Positive**

Results in millimeters must be given:_____mm

Administered by: _____ **Read by:_____**
(<u>Please sign</u>) **(<u>Please sign</u>)**

……..

<u>Step Two should be given within 1-3 weeks after initial test is read</u>

<u>Step Two of Two-Step</u>

Administration **Interpretation (Read in 48-72 Hours)**

Date of administration: _____/_____/_____ **Date read: _____/_____/_____**

Lot #_____Exp. Date:_____ **Result: _____Negative or _____Positive**

Results in millimeters must be given:_____mm

Administered by: _____ **Read by:_____**
(<u>Please sign</u>) **(<u>Please sign</u>)**

Alternative Test to Two-Step PPD: QuantiFERON Gold Blood Test (Document test on page 4 of this health form)

Initial Health Evaluation Form: RMU Nursing Program

Student Name: (please print) _____

QuantiFERON Gold Blood Test (Alternative Test to Two-Step PPD)

Date of QuantiFERON Gold blood test:_____

Results QuantiFERON Gold blood test for TB: _____Negative or _____Positive

May provide documentation with lab report

CHEST X-RAY Required if either PPD or QuantiFERON Gold Blood Test are POSITIVE Provide documentation with Chest X-ray report

If positive PPD or QuantiFERON Gold blood test:

Chest x-ray Date:_____ Result: _____ Normal ____ Abnormal

Treated for positive PPD or QuantiFERON Test: ____ Yes ____ No

Treatment:_____ Start Date: _____

Duration:_____ Completion Date:_____

Please note:

If there is positive testing for Tuberculosis as a result of either PPD skin testing or QuantiFERON Gold blood test, the document on page 5 of this health form must be read and then signed and dated by the nursing student.

RMU Nursing Student with Positive PPD Testing Results **Name:**_____
(Please Print)

Students who have a positive PPD test for Tuberculosis will be required to have a chest x-ray done to rule out active disease. This must be done at the time of the initial positive test and/or the Initial Health Evaluation that is required by the School of Nursing. Documentation of the x-ray results must be submitted.

Once positive, a PPD test will be positive with future testing. Therefore, no further PPD test will be repeated. A positive test does not mean that the individual has active disease/infection, but it can mean that at some point there has been exposure to active disease particularly if the individual has lived in a part of the world where tuberculosis is indigenous to the area. Examples of such parts of the world might include: India, Russia, China, Haiti, Thailand, Africa, South Pacific Islands, and Southeast Asian countries.

The Allegheny County Department of Health which follows CDC guidelines does not necessarily recommend that a student with a positive PPD have a yearly chest x-ray, although it is required that a chest x-ray be done if signs of active disease develop or if the student has been around a known active case. Symptoms of Tuberculosis include a persistent productive cough (may include coughing up blood) unexplained weight loss, repeated night sweats, loss of appetite, fever, chills, and general lethargy.

The student should sign the agreement that follows:

I, the undersigned understand that development of active disease (Tuberculosis) is very serious and that contact with an individual with active disease puts those with whom they come into contact at high risk for developing Tuberculosis.

If I, the undersigned, should develop the signs and symptoms of Tuberculosis, I will immediately seek assessment and treatment from my healthcare provider. At that time, a chest x-ray should be repeated with initiation of TB drug therapy if the healthcare provider suspects Tuberculosis as a diagnosis. I understand that I will not be permitted to attend class or clinical while considered contagious until I have received documented clearance to do so from my healthcare provider.

Furthermore, I, the undersigned, will report any travel done to parts of the world that have a high incidence of tuberculosis within the population to the Department of Nursing. If the travel has been extensive in length, (i.e., 3 months or more) a repeat chest x-ray may be required.

In addition to the above, I will comply with any clinical agency policies that pertain to those with positive PPD testing and/or development of active Tuberculosis.

I have read the above, understand the information, and agree to the requirements stated herein.

_____ _____

Signature Date

Initial Health Evaluation Form: RMU Nursing Program

Student Name: (please print) _____

1. I have obtained a health history and performed a complete 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_____

Initial Health Evaluation Form: RMU Nursing Program

Student Name: (please print) _____

Completion by Student Nurse in the RMU Nursing Program

Clinical Agency Permission: (Select the option, 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 my insurance card (front and back)

Signature of Student: _____ Date: _____

It is the ongoing responsibility of the student to inform the 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
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