**UNIVERSITY OF PITTSBURGH AT JOHNSTOWN**

**ANNUAL HEALTH APPRAISAL FOR NURSING**

All nursing students must have an Initial Health Evaluation upon admission to the nursing program, plus an Annual Update Evaluation until completion of the program. Students WILL NOT be permitted to register or participate in clinical activities until the completed health form has been submitted.

\*\*\*\*\*IMPORTANT\*\*\*\*\*

**Your Healthcare Provider must complete the TB and Hep B portions on the health form in addition to the Healthcare Provider information section. Appropriate paperwork for the TB/Quantiferon Gold test must be attached to the health form as indicated.**

The health form MUST BE COMPLETED IN ITS ENTIRETY. Incomplete forms will be rejected.

**Completed HEALTH FORM and ACCOMPANYING PAPERWORK**

**must be uploaded into**

 **Project Concert**

**NO LATER THAN MAY 1ST.**

**UNIVERSITY OF PITTSBURGH AT JOHNSTOWN**

 **ANNUAL HEALTH APPRAISAL FOR NURSING**

*Please print unless otherwise indicated. ALL date fields required by this form must be legible and completed with month, date, and year values. Failure to comply with these requests will prevent your registration for the upcoming term and will prevent your clinical rotations.*

**STUDENT INFORMATION**

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Initial\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PeopleSoft ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Male\_\_\_\_\_ Female\_\_\_\_\_ Student Level \_\_\_\_\_FR \_\_\_\_\_SO\_\_\_\_\_JR\_\_\_\_\_SR

Street\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code\_\_\_\_\_\_\_\_\_

Emergency Contact Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH INSURANCE**

I verify that I carry, and will carry for the entire duration of my program, health insurance that will cover payment of treatment and follow-up procedures related to bloodborne pathogens, other potentially infectious materials, and any illness or injury that could occur during class or clinical.

Student Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*\*\*IMPORTANT NOTICE\*\*\*\*\***

**Healthcare Provider Must Complete This Section**

Results for TUBERCULOSIS SCREENING (2 STEP PPD TEST) or QUANTIFERON GOLD TEST

**MUST** be reviewed by a Healthcare Provider and **attached to this form.**

**OR**

**QUANTIFERON GOLD TB Blood Test**

Date Read MM/DD/YY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results:\_\_\_\_\_Negative \_\_\_\_\_Positive

**If Tuberculin Skin Test is Positive, MUST**

**Have Chest X-Ray.**

Date of Chest X-Ray (MM/DD/YY):\_\_\_\_\_\_\_\_\_

Results: \_\_\_\_\_Normal \_\_\_\_\_Abnormal

**TUBERCULOSIS SCREENING (2 Step PPD)**

(Mantoux required. The second PPD Test must be administered 1-3 weeks after first PPD Test.)

Date Read Test 1 (MM/DD/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results: \_\_\_\_\_Negative \_\_\_\_\_Positive

Date Read Test 2 (MM/DD/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results: \_\_\_\_\_Negative \_\_\_\_\_Positive

**If Tuberculin Skin Test is Positive, MUST have**

**Chest X-Ray.**

Date of Chest X-Ray (MM/DD/YY): \_\_\_\_\_\_\_\_\_\_

Results: \_\_\_\_\_Normal \_\_\_\_\_Abnormal

**\*\*\*\*\*Healthcare Provider Must Complete This Section \*\*\*\*\***

**HEPATITIS B**

Indicate date of last HEP B Titer and results (MM/DD/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results: \_\_\_\_\_Immune \_\_\_\_\_Non-Immune

**TETANUS-DIPTHERIA-PERTUSSIS**

Tdap Booster Date (MM/DD/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STUDENT MUST HAVE HAD Tdap Booster within the past 10 years. IF NOT, MUST GET BOOSTER.

**\*\*\*\*\*Healthcare Provider Must Complete This Section\*\*\*\*\***

*I have obtained a health history, performed a physical examination, and reviewed the student’s immunization status and required laboraty tests. In my opinion, this student is able to fully participate in the school of nursing program:*

Signature of Healthcare Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD\_\_\_\_\_DO\_\_\_\_\_CRNP\_\_\_\_\_PA\_\_\_\_\_

Name (Please Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date (MM/DD/YY)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If this student is NOT fully able to participate, please comment on activity limitations:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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