**UNIVERSITY OF PITTSBURGH AT JOHNSTOWN**

**INITIAL 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 #1 through #8 on the health form in addition to the Healthcare Provider information section. Appropriate paperwork 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 AUGUST 1ST.**

**UNIVERSITY OF PITTSBURGH AT JOHNSTOWN**

**INITIAL 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**

1. **TETANUS-DIPTHERIA** (Primary Series (DIP) in Childhood)

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

Completed? \_\_\_\_\_Yes \_\_\_\_\_No (Primary Series or Tetanus Booster Must Be Within 10 Years)

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

1. **POLIO** (Primary Series (DtP) in Childhood)

Completed? \_\_\_\_\_Yes \_\_\_\_\_No

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

1. **HEPATITIS B** (Must Show History of Vaccine Series and Post-Vaccination Immunity)

Results for HEPATITIS B **MUST** be reviewed by a Healthcare Provider and **attached to this form**.

Vaccine Dose 1 Date (MM/DD/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vaccine Dose 2 Date (MM/DD/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vaccine Dose 3 Date (MM/DD/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AND**

Titer Date (MM/DD/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_Immune \_\_\_\_\_Non-Immune

(If Non-Immune, must REPEAT 3 Vaccine Series or receive Booster, followed by another Titer to show Immunity.)

**Healthcare Provider Must Complete This Section (cont.)**

**Clinical contracts require that you must have titers drawn for BOTH Rubeola and Rubella to determine if you are immune, regardless of prior illness or immunization history. If titers were drawn in the past and showed that you were non-immune, you will need a MMR booster. If it has been longer than 6 months since the booster, you will need another titer(s) to see if the immunization has provided immunity.**

4) **RUBEOLA/Measles** (If it has been over 6 months since last booster, a new titer is necessary.)

Titer Date (MM/DD/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results: \_\_\_\_\_Immune \_\_\_\_\_Non-Immune (If Non-Immune, current booster date (within 6 months).

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

(If equivocal, Health Care Provider must provide statement and initials: \_\_\_\_\_\_\_. You are considered to be

Non- Immune until another Titer proves otherwise.)

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

5) **RUBELLA** (If it has been over 6 months since last booster, a new titer is necessary.)

Titer Date (MM/DD/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results: \_\_\_\_\_Immune \_\_\_\_\_Non-Immune (If Non-Immune, current booster date (within 6 months).

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

(If equivocal, Health Care Provider must provide statement and initials: \_\_\_\_\_\_\_. You are considered to be

Non- Immune until another Titer proves otherwise.)

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

6) **MUMPS**

Vaccine Dose (MM/DD/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OR**

Titer Date (MM/DD/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_Immune \_\_\_\_\_Non-Immune

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

7) **VARICELLA/Chicken Pox** (Either a history of chicken pox, a positive Varicella antibody, or 2 doses of vaccine given at least one month apart if immunized at the age of 13 or older meets the requirement.

History of Disease: \_\_\_\_\_Yes \_\_\_\_\_No

Vaccine Dose 1 (MM/DD/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vaccine Dose 2 (MM/DD/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OR**

Titer Date (MM/DD/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Results: \_\_\_\_\_Immune \_\_\_\_\_Non-Immune

**Healthcare Provider Must Complete This Section (cont.)**

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

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

8) **OR**

**QUANTIFERON GOLD TB Blood Test**

Date Read Test 1 (MM/DDD/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 (cont.)**

*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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Completed HEALTH FORM and ACCOMPANYING PAPERWORK**

**must be uploaded into**

**Project Concert**

**NO LATER THAN AUGUST 1ST.**