

Name: _____
(Please Print)

Student Identification #: _____
(7 Digit #)

UNIVERSITY OF PITTSBURGH SCHOOL OF NURSING INITIAL HEALTH APPRAISAL FORM

The University Pittsburgh School of Nursing, in keeping with the rules and regulations of the State Board of Nursing and health care agencies, requires all students to complete certain admission health screening procedures. If you have any questions relating to the requirements, please call the Student Health Services at (412) 383-1832.

All students are required to provide health history information and to have a health evaluation upon admission to the School of Nursing.
THIS HEALTH FORM MUST BE COMPLETED BEFORE STUDENTS CAN START CLASSES.

- Pre-licensure BSN Students will be required to submit an "Annual Health Appraisal Form" by end of February each year prior to Fall term registration.
- Graduate Students may be required to submit additional health information to their program coordinator.
- Lab results that are submitted without requested documentation on form, or use of other health evaluation forms (e.g. work physicals), will not be accepted.
- Please check the health form for completeness before submitting it to the Student Health Services and make a copy of the form for your records. Hand-carry or send the completed form to the:

University of Pittsburgh
Student Health Service
Medical Arts Building
Suite 500
3708 Fifth Avenue
Pittsburgh, PA 15213

HEALTH INSURANCE INFORMATION

ATTENTION All School of Nursing Students: You must carry, and be prepared to show evidence that you have current health insurance. This is a requirement for the entire duration of your program. This health insurance must cover you for any treatments related to bloodborne pathogens, other potentially infectious materials, and any illness or injury that could occur during class or clinical.

DISABILITY INFORMATION

If you have a health problem that may require individualized disability support services, it is your responsibility to contact:

Disability Resources and Services
216 William Pitt Union
Pittsburgh, Pa. 15260
412-648-7890
www.drs.pitt.edu

ALL DATE FIELDS ON THIS FORM MUST BE LEGIBLE AND COMPLETED WITH MONTH, DAY, AND YEAR VALUES.

(Failure to comply will prevent your registration for upcoming Term and prevent your participation in Clinicals)

(MUST BE COMPLETED BY STUDENT)

I verify that I have read and understand all information listed above.

(Student Signature)

Date _____ / _____ / _____
(Month / Day / Year)

*** FOR SHS OFFICIAL USE ONLY ***
After Data Entry Complete, Initial Here:

Name: _____
(Please Print)

Student Identification #: _____
(7 Digit #)

STUDENT LEVEL Freshman / Sophomore / Junior / Senior / Graduate / PhD / Accelerated / RN Option / DNP
(Circle One For Upcoming Term)

PART I: STUDENT INFORMATION

(ALL AREAS MUST BE COMPLETED BY STUDENT)

STUDENT IDENTIFICATION NUMBER _____ (NOT Campus ID Card Number; NOT Personal SSN)

DATE OF BIRTH _____ / _____ / _____ GENDER? Male / Female (circle one)
(Month / Day / Year)

NAME _____ / _____ / _____
(Last Name) (First Name) (Middle)

ADDRESS _____ / _____
(Street) (City/State/Zip Code)

TELEPHONE (_____) _____

Emergency Contact Person: (state their name, relationship to you, address, & phone number below)

(MUST BE COMPLETED BY STUDENT)

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 _____ / _____ / _____
(Month / Day / Year)

PART II: IMMUNIZATION / VACCINATION HISTORY

(STUDENT OR HEALTH CARE PROVIDER TO COMPLETE)

TETANUS-DIPHTHERIA

PRIMARY SERIES (DTP) (in childhood) COMPLETED? YES / NO (circle one)

BOOSTER DATE _____ / _____ / _____ *** Student must have had tetanus booster within the past 10 years (or must get booster)
(Month / Day / Year)

POLIO

PRIMARY SERIES (in childhood) COMPLETED? YES / NO (circle one)

HEPATITIS B

VACCINE DOSE 1 _____ / _____ / _____ DOSE 2 _____ / _____ / _____ DOSE 3 _____ / _____ / _____
(Month / Day / Year) (Month / Day / Year) (Month / Day / Year)

OR

TITER DATE _____ / _____ / _____ RESULTS? Immune / Non-Immune (circle one)
(Month / Day / Year)

OR

Check that you are attaching a signed refusal form (available in the Student Services Office) if immunization is contraindicated

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HEPATITIS A and MENINGITIS

Immunizations / vaccinations for these are currently not a School of Nursing* requirement; however, we suggest discussing them with your Health Care Provider.

*** Vaccination for Meningitis is a University requirement for campus residents, all freshman students and all transfer students. Please follow the University instructions regarding submission of proper documentation.

PART III: LABORATORY/DIAGNOSTIC TEST INFORMATION

(STUDENT OR HEALTH CARE PROVIDER TO COMPLETE)

TUBERCULOSIS SCREENING

TUBERCULIN SKIN TEST (PPD must be within 1 year)

DATE READ _____ / _____ / _____
(Month / Day / Year)

RESULTS?

Negative / Positive (circle one)

CHEST X-RAY (Required if tuberculin skin test is Positive)

XRAY DATE _____ / _____ / _____
(Month / Day / Year)

RESULTS?

Normal / Abnormal (circle one)

Comments (Required if tuberculin skin test is Positive) : _____

VARICELLA (CHICKENPOX)

(Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized at the age of 13 or older meets the requirement.)

HAVE HISTORY OF DISEASE

HISTORY?

YES / NO (circle one)

OR

VACCINE DOSE 1 _____ / _____ / _____
(Month / Day / Year)

DOSE 2

_____ / _____ / _____
(Month / Day / Year)

OR

TITER DATE _____ / _____ / _____
(Month / Day / Year)

RESULTS?

Immune / Non-Immune (circle one)

MUMPS

Born before 1957 (Check if Applicable)

OR

VACCINE DOSE _____ / _____ / _____
(Month / Day / Year)

OR

TITER DATE _____ / _____ / _____
(Month / Day / Year)

RESULTS?

Immune / Non-Immune (circle one)

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. 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.

RUBEOLA (MEASLES)

(IF IT HAS BEEN OVER 6 MONTHS SINCE THE LAST BOOSTER, A NEW TITER IS NECESSARY)

TITER DATE _____ / _____ / _____
(Month / Day / Year)

RESULTS?

Immune / Non-Immune (circle one)

BOOSTER DATE _____ / _____ / _____
(Month / Day / Year)

*** IF NON-IMMUNE, PLEASE GIVE CURRENT BOOSTER DATE (WITHIN 6 MONTHS)

If equivocal, Health Care Provider must provide statement and initials : _____
(IF EQUIVOCAL, YOU ARE CONSIDERED TO BE NON-IMMUNE UNTIL ANOTHER TITER PROVES OTHERWISE)

Name: _____
(Please Print)

Student Identification #: _____
(7 Digit #)

RUBELLA

(IF IT HAS BEEN OVER 6 MONTHS SINCE THE LAST BOOSTER, A NEW TITER IS NECESSARY)

TITER DATE _____ / _____ / _____
(Month / Day / Year)

RESULTS?

Immune / Non-Immune (circle one)

BOOSTER DATE _____ / _____ / _____
(Month / Day / Year)

*** IF NON-IMMUNE, PLEASE GIVE CURRENT BOOSTER DATE (WITHIN 6 MONTHS)

If equivocal, Health Care Provider must provide statement and initials : _____
(IF EQUIVOCAL, YOU ARE CONSIDERED TO BE NON-IMMUNE UNTIL ANOTHER TITER PROVES OTHERWISE)

PART IV: EXAM EVALUATION AND VERIFICATION
(HEALTH CARE PROVIDER TO COMPLETE)

I have obtained a health history, performed a physical examination and reviewed the student's immunization status and required laboratory tests. In my opinion this student is able to fully participate in the School of Nursing program:

Yes / No (circle one)

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

NOTICE: The YEAR on the Provider date below must correspond with the upcoming calendar year that is going to be covered by the data on this form.

PROVIDER INFORMATION

Name _____
(Please Print)

CRNP / MD / DO / PA (circle one)

Signature _____

Date _____ / _____ / _____
(Month / Day / Year)

Phone Number: _(_____)_____