University of Pittsburgh School of Nursing
Annual Health Form

THE INFORMATION CAN BE ENTERED BY THE STUDENT. ALL INFORMATION MUST BE IN ENGLISH. THIS FORM REQUIRES A HEALTH CARE PROVIDER (PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT) SIGNATURE on Page 2.

PART I: STUDENT INFORMATION

(ALL FIELDS MUST BE COMPLETED)

STUDENT IDENTIFICATION NUMBER:______________________________________

NAME: ____________________________________/__________________________________/ _____________________

(LAST NAME) (FIRST NAME) (Middle Initial)

STUDENT LEVEL: (Please check the appropriate level)

___ Sophomore ___ Junior ___ Senior ___ Second Degree Accelerator ___ RN Options

___ MSN ___ DNP ___ PhD ___ Certificate Program

ADDRESS ____/ ____

(STREET) (CITY/STATE/ZIP)

TELEPHONE: ____ E-MAIL: ______________________

Health Insurance (must be completed by student):

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 (MONTH/DAY/YEAR)

PART II: TB Screening Information (Health Care Provider must Complete)

TB Screening: One of the following is required

1. TUBERCULOSIS SKIN TEST	1. Date Read Test: ____/______/ ______ 2. RESULT: ☐ POSITIVE ☐ NEGATIVE
CHEST X-RAY (Required if tuberculin skin test is Positive)	1. Chest X-Ray Date: ______/______/ ______ 2. RESULT: ☐ NORMAL ☐ ABNORMAL
2. TUBERCULOSIS QUANTIFERON GOLD BLOOD TEST	1. Date Read Test 1:_______/_____/ _____ 2. RESULT: ☐ POSITIVE ☐ NEGATIVE 3. Chest X-Ray Date: (Required if tuberculin skin test is Positive) ______/______/ ______ 4. RESULT: ☐ NORMAL ☐ ABNORMAL

PART III: EXAM EVALUATION AND VERIFICATION/ PROVIDER INFORMATION

(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:

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

____

____

Name: ____

Signature: ____

Date_______/_______/ _______

Phone: ____

Note: ALL SECTIONS ON THIS FORM MUST BE COMPLETED BEFORE ITS SUBMISSION!
Upon completion, this form should be scanned and uploaded by the student to ProjectConcert (my.pitt.edu>Academic Resources>SON-ProjectConcert>Information>Documents).
(Form Revised.: 8/24/17)