University of Pittsburgh School of Nursing
Initial Health Form

DATA AND IMMUNIZATION RECORD

THE INFORMATION CAN BE ENTERED BY THE FACULTY. ALL INFORMATION MUST BE IN ENGLISH. **COPIES** OF ORIGINAL RECORDS ARE ALSO ACCEPTABLE. **DO NOT SEND ORIGINAL RECORDS.** THIS FORM REQUIRES A PHYSICIAN'S SIGNATURE on Page 4.

PART I: STUDENT INFORMATION

(ALL FIELDS MUST BE COMPLETED)

DATE OF BIRTH _____ SEX _____
(MONTH/DAY/YEAR)

NAME _____/_____/_____
(LAST NAME) (FIRST NAME) (MIDDLE NAME)

ADDRESS _____/_____
(STREET) (CITY/STATE/ZIP)

TELEPHONE _____ E-MAIL _____

EMERGENCY CONTACT PERSON _____ CONTACT RELATIONSHIP _____

CONTACT PHONE NUMBER _____ ADDRESS _____/_____
(STREET) (CITY/STATE/ZIP)

Health Insurance (must be completed by student):
I verify that I carry, and will carry 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: Immunization / Vaccination History (Health Care Provider to Complete)

TETANUS-DIPTHERIA-PERTUSSIS Primary Series (Tdap) (In Childhood)	1. Booster date: ____/_____/ _____	2. Primary series completed: Yes _____ No _____ Date completed:____/_____/ _____ **(Primary series completed within past 10 years or Tetanus, Diphtheria, Pertussis (Tdap) booster within past 10 years)**		
POLIO (Primary Series (DtP) (In Childhood)	1. Completed? Yes _____ No _____			
HEPATITIS B	Dose 1 _____/_____/ _____	Dose 2 _____/_____/ _____	Dose 3 _____/_____/ _____	☐ Place an X in the box when you are attaching a signed REFUSAL FORM if immunization is contraindicated (Refusal Form is available in Wellness Center Office)
OR **HEPATITIS B Titer Date**	_____/_____/ _____	Results: Immune _____ NOT Immune _____ If NOT immune: Booster given or immunization series began: Date: _____/_____/ _____		

PART III: Laboratory / Diagnostic Test Information (Health Care Provider to Complete)

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.

MEASLES (Rubeola)	1. Titer Date _____/_____/ _____ 2. Results: 1) immune _____ 2) NOT immune _____ (if NOT immune, current booster date - must be within 6 months) 3) Booster Date:_____/_____/ _____ If equivocal, Health Care Provider must provide statement and initials: _____ **(IF EQUIVOCAL, YOU ARE CONSIDERED TO BE NON-IMMUNE UNTIL ANOTHER TITER PROVES OTHERWISE)**

RUBELLA	1. Titer Date _____/_____/ _____ 2. Results: 1) immune _____ 2) NOT immune _____ (if NOT immune, current booster date - must be within 6 months) 3) Booster Date:_____/_____/ _____ If equivocal, Health Care Provider must provide statement and initials: _____ **(IF EQUIVOCAL, YOU ARE CONSIDERED TO BE NON-IMMUNE UNTIL ANOTHER TITER PROVES OTHERWISE)**
MUMPS	If born before 1957, place an X in the box ☐ 1. LAST DOSE: _____ /_____ /_____ **OR** 2a. Titer Date _____/_____/_____ 2b. Results: 1) immune _____ 2) NOT immune _____ 2c. If NOT immune: Booster given or immunization series began: Date:_____/_____/ _____
VARICELLA HISTORY OF CHICKEN POX, A POSITIVE VARICELLA ANTIBODY, OR TWO DOSES OF VACCINE GIVEN AT LEAST ONE MONTH APART ARE REQUIRED. IN CASE OF HISTORY OF DISEASE, PLACE DATE OF DISEASE IN FIRST DATE FIELD.	If History of disease, give date _____/_____ /_____ 1. Vaccine Dose 1 _____/_____/ _____ 2. Vaccine Dose 2 _____/ _____/ _____ **OR** 3a. Titer Date: _____/_____/ _____ 3b. Results: 1) immune _____ 2) NOT immune _____ 3c. If NOT immune: Booster given or immunization series began: Date:_____/_____/ _____
MENINGOCCOCAL QUADRIVALENT (meningitis) **REQUIRED IF LIVING IN UNIVERSITY HOUSING.** TWO DOSES ARE REQUIRED, WITH ONE DOSE ADMINISTRATED AT 16 YEARS OF AGE OR OLDER.	If History of disease, give date _____/_____ /_____ 1. Vaccine Dose 1 _____/_____/ _____ 2. Vaccine Dose 2 _____/_____/ _____ **OR** 3a. Titer Date:_____/_____/ _____ 3b. Results: 1) immune _____ 2) NOT immune _____ 3c. If NOT immune: Booster given or immunization series began: Date:_____/_____/ _____

TB Screening: One of the following is required

1. TUBERCULOSIS SKIN TEST	1. Date Read Test: ____ / ____/ _____ 2. RESULT: ☐ POSITIVE ☐ NEGATIVE
2. TUBERCULOSIS QUANTIFERON GOLD BLOOD TEST	1. Date Read Test 1: _____/_____/_____ 2. RESULT: ☐ POSITIVE ☐ NEGATIVE
CHEST X-RAY (If there was a positive TB test, at the time of this health screen or in the past, the results of the follow-up chest x-ray must to be reported and the attached symptom checklist must be completed.)	1. Chest X-Ray Date: _____/_____/ _____ 2. RESULT: ☐ NORMAL ☐ ABNORMAL

PART IV: 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: _____

Medical TB Questionnaire

Please answer the following questions about signs and symptoms of tuberculosis.

Are you coughing up blood-streaked sputum and/or having chest pain while coughing?	☐ YES ☐ NO
Had you had a productive cough lasting longer than 3 weeks?	☐ YES ☐ NO
Have you had unexplained night sweats, fever, or fatigue?	☐ YES ☐ NO
Have you had unexplained loss of appetite or weight loss?	☐ YES ☐ NO

Note: ALL SECTIONS ON THIS FORM MUST BE COMPLETED BEFORE IT IS SUBMITTED!

Upon completion, this form should be scanned and uploaded by the student to EXXAT.