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| **Robert Morris University (RMU)**  **School of Nursing and Health Sciences**  **INITIAL HEALTH EVALUATION FORM** |

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| Name: |  |
| Address: |  |
| Phone Number: |  |

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| **Instructions for Completion of the Initial Health Evaluation Form**  **Directions for the Healthcare Provider (Physician, Nurse Practitioner, Physician Assistant)** |

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| * Perform a health history and a complete physical exam. * Fill out the health evaluation form completely, recording all required information directly onto this form. * Attachments, such as lab reports, copies of immunization records, etc., are required as indicated on this form. * Immunizations are to be up-to-date as recommended by the CDC. * Titers are required as indicated on the form. * Initial required PPD is a Two-Step; a One-Step PPD is then required annually. * Signature of the Healthcare Provider with the date of the exam is required on this form. |

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| **Directions for the RMU Student** |

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| * The student is responsible for the health form being completed fully as required. * Complete up-to-date health evaluations are an ongoing requirement for attendance at clinical with annual health updates necessary. * The student must sign and date the "Clinical Agency Permission." * The student must sign and date the "Student’s Health Insurance Agreement." * A copy of the insurance card (front and back) is also to be submitted. |

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| **Initial Health Evaluation Form: RMU School of Nursing and Health Sciences** |
| **Name (print)** |

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| **RECORD OF IMMUNIZATIONS** | | | |
| **Immunization** | **Completed Series** |  | **Dates** |
| **TDaP/TD** | □ Yes □ No | **TDap (required) within last 10 years:** | Date:  \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| **Varicella**  ***Series in process is not acceptable*** | □ Yes □ No  □ History of disease | **Booster:**  □ Yes □ No | Date(s) of immunization:  \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| **MMR**  ***Series in process is not acceptable*** | □ Yes □ No  □ History of disease |  | Date(s):  \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| **Hepatitis B**  ***Series in process is acceptable*** | □ Yes □ No |  | Date(s):  \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |

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| **Initial Health Evaluation Form: RMU School of Nursing and Health Sciences** |
| **Name (print)** |

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| **REQUIRED TITERS AND LAB REPORT DOCUMENTATION** | | |
| **Date of Titer** | **Titer Results/Test Interpretation** | **Recommendation** |
| ***Rubeola*** (Measles) ***Titer Required***  Date of Titer: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ | □ Immune  □ Non-Immune | **The student should obtain a copy of the lab report for his or her records.** |
| **Mumps *Titer Required***  Date of Titer: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ | □ Immune  □ Non-Immune | **The student should obtain a copy of the lab report for his or her records.** |
| ***Rubella*** (German Measles) ***Titer Required***  Date of Titer: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ | □ Immune  □ Non-Immune | **The student should obtain a copy of the lab report for his or her records.** |
| ***Varicella*** (Chicken Pox) ***Titer Required***  Date of Titer: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ | □ Immune  □ Non-Immune | **The student should obtain a copy of the lab report for his or her records.** |
| ***Hepatitis B Titer Required* if series of 3 vaccinations are not documented by immunization dates on this form**  Date of Titer: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ | □ Immune  □ Non-Immune | **The student should obtain a copy of the lab report for his or her records.** |

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| ***Influenza Vaccination*** | □ Yes □ No | Required yearly | Date:  \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| If “no”, please complete page 8. | | | |

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| **Initial Health Evaluation Form: RMU School of Nursing and Health Sciences** |
| **Name (print)** |

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| **History of prior reaction to Two-Step PPD (Mantoux) Test:**  **Yes \_\_\_\_\_ No\_\_\_\_\_\_** |
| **If yes, was a screening for signs and symptoms of Tuberculosis completed?**  **Yes \_\_\_\_\_ No\_\_\_\_\_\_** |
| **If positive, date of last chest x-ray:** |
| **X-Ray Results:** |
| **Treatment:** |

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| **Two-Step PPD (TB Testing)** | | |
| **Step One of Two-Step**  **Administration Interpretation (Read in 48-72 Hours)**  **Date of administration: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Date read: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **Lot #\_\_\_\_\_\_\_\_\_\_\_\_\_\_Exp. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_Negative or \_\_\_\_\_Positive**  **Results in millimeters must be given:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_mm**  **Administered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Read by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **(Please sign) (Please sign)**  ***Step Two should be given within 1-3 weeks after initial test is read***  **Step Two of Two-Step**  **Administration Interpretation (Read in 48-72 Hours)**  **Date of administration: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Date read: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**  **Lot #\_\_\_\_\_\_\_\_\_\_\_\_\_\_Exp. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_Negative or \_\_\_\_\_Positive**  **Results in millimeters must be given:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_mm**  **Administered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Read by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **(Please sign) (Please sign)** | | |
| **Initial Health Evaluation Form: RMU School of Nursing and Health Sciences** |
| **Name (print)** |

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| **QuantiFERON Gold Blood Test (Alternative Test to Two-Step PPD)** |

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| **Date of QuantiFERON Gold blood test:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Results QuantiFERON Gold blood test for TB: \_\_\_\_\_ negative or \_\_\_\_\_ positive**  **May provide documentation with lab report** |

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| **CHEST X-RAY Required if either PPD or QuantiFERON Gold Blood Test are POSITIVE**  **Provide documentation with Chest X-ray report** |

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| **If positive PPD or QuantiFERON Gold blood test:**  **Chest x-ray Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_ Normal \_\_\_\_ Abnormal**  **Treated for positive PPD or QuantiFERON Test: \_\_\_\_ Yes \_\_\_\_ No**  **Treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Completion Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Please note:**

**If there is positive testing for Tuberculosis as a result of either PPD skin testing or QuantiFERON Gold blood test, the document on page 6, of this health form, must be read and then signed and dated by the student.**

**Positive PPD Testing Results Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Please Print)**

Those who have a positive PPD test for Tuberculosis will be required to have a chest x-ray done to rule out active disease. This mustbe done at the time of the initial positive test and/or the Initial Health Evaluation that is required by the School of Nursing and Health Sciences. Documentation of the x-ray results must be submitted.

Once positive, a PPD test will be positive with future testing. Therefore, no further PPD test will be repeated. A positive test does not mean that the individual has active disease/infection, but it can mean that at some point there has been exposure to active disease particularly if the individual has lived in a part of the world where tuberculosis is indigenous to the area. Examples of such parts of the world might include: India, Russia, China, Haiti, Thailand, Africa, South Pacific Islands, and Southeast Asian countries.

The Allegheny County Department of Health which follows CDC guidelines does not necessarily recommend that those with a positive PPD have a yearly chest x-ray, although it is required that a chest x-ray be done if signs of active disease develop or if the student has been around a known active case. Symptoms of Tuberculosis include a persistent productive cough (may include coughing up blood) unexplained weight loss, repeated night sweats, loss of appetite, fever, chills, and general lethargy.

**The student should sign the agreement that follows:**

I, the undersigned understand that development of active disease (Tuberculosis) is very serious and that contact with an individual with active disease puts those with whom they come into contact at high risk for developing Tuberculosis.

If I, the undersigned, should develop the signs and symptoms of Tuberculosis, I will immediately seek assessment and treatment from my healthcare provider. At that time, a chest x-ray should be repeated with initiation of TB drug therapy if the healthcare provider suspects Tuberculosis as a diagnosis. I understand that I will not be permitted to attend class or clinical while considered contagious until I have received documented clearance to do so from my healthcare provider.

Furthermore, I, the undersigned, will report any travel done to parts of the world that have a high incidence of tuberculosis within the population to the School of Nursing and Health Sciences. If the travel has been extensive in length, (i.e., 3 months or more) a repeat chest x-ray may be required.

In addition to the above, I will comply with any clinical agency policies that pertain to those with positive PPD testing and/or development of active Tuberculosis.

**I have read the above, understand the information, and agree to the requirements stated herein.**

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

Signature Date

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| **Initial Health Evaluation Form: RMU School of Nursing and Health Sciences** | | | |
| **Name (print)** | | | |
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| **Student identification verified by:** | | | |
|  | **print name** |  |  |

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| **Initial Health Evaluation Form: RMU School of Nursing and Health Sciences** |

**One Step Qualitative Urine Screening Assay**

**For the detection of Cannabinoids (THC), Cocaine, Opiates, Amphetamines and Phencyclidine (PCP) in human urine.**

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| **Qualitative Urine Screening A** | | |
|  | **Valid** | **Invalid** |
| **Control** |  |  |
|  | **Negative** | **Non-Negative** |
| **THC** |  |  |
| **COC** |  |  |
| **OPI** |  |  |
| **AMP** |  |  |
| **PCP** |  |  |
| **PLACEMENT OF HEALTHCARE PROVIDER’S OFFICIAL OFFICE STAMP:** | | |
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**Declination of Influenza Vaccination**

Robert Morris University (RMU) and the clinical affiliates of the RMU Nuclear Medicine Technology program have recommended that I receive influenza vaccination to protect the patients I serve.

I acknowledge that I am aware of the following facts:

Influenza is a serious respiratory disease that kills thousands of people in the United States each year.

* Influenza vaccination is recommended for me and all other healthcare workers to protect this facility’s patients from influenza, its complications, and death.
* If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
* If I become infected with influenza, even if my symptoms are mild or non-existent, I can spread it to others and they can become seriously ill.
* I understand that the strains of virus that cause influenza infection change almost every year and, even if they don’t change, my immunity declines over time. This is why vaccination against influenza is recommended each year.
* I understand that I cannot get influenza from the influenza vaccine.

The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including:

* all patients in this healthcare facility
* my coworkers
* my family
* my community

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| Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons: |
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I understand that I can change my mind at any time and accept influenza vaccination, if vaccine is still available.

I have read and fully understand the information on this declination form.

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| --- | --- |
| Signature: |  |
| Name (print): |  |
| Date: |  |

Reference: CDC. Prevention and Control of Influenza with Vaccines—Recommendations of ACIP at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html

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| **Initial Health Evaluation Form: RMU School of Nursing and Health Sciences** |
| **Name (print)** |

1. I have obtained a health history and performed a complete physical exam.

If no, please explain \_\_\_\_ Yes \_\_\_\_\_ No

1. In my opinion, based on my assessment, the student has no cognitive, sensory, psychological or physical limitations (vision, hearing, speech, touch, smell, reading/language, writing, movement, lifting)that would prevent him/her from fully participating in the Department of Health Sciences Programs, or providing safe care.

If no, please explain. \_\_\_\_ Yes \_\_\_\_ No

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Name (Please print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD/DO/CRNP/PA

(Circle)

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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| **PLACEMENT OF HEALTHCARE PROVIDER’S OFFICIAL OFFICE STAMP:** |
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| **Initial Health Evaluation Form: RMU School of Nursing and Health Sciences** | | |
| **Name (print)** | | |

***To be completed by the student***

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| **Clinical Agency Permission: (Select the option, sign, and date)**  \_\_\_\_ I give permission to release my medical information to the course-related clinical agencies.  I hereby release the clinical agency, Robert Morris University and their respective agents, officers, trustees, directors and employees from any and all claims, including but not limited to, claims of defamation, invasion of privacy, wrongful dismissal, negligence, or any other damages resulting from or pertaining to the collection, dissemination or use of this information.  Signature of Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Health Insurance Agreement: (Student signs and dates)**  I verify that I am covered by health insurance. I agree to maintain health insurance coverage throughout the program which includes, but is not limited to, payment for treatment and follow-up procedures, including exposure to blood-borne pathogens as well as other potentially infectious materials. I include a copy of my insurance card (front and back)  Signature of Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| ***It is the ongoing responsibility of the student to inform the Department Head of any significant changes in his or her health status.*** |

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| ***Academic action may include removal from clinical activities or dismissal if there has been deliberate misrepresentation of information in any manner on this health form.*** |