University of Pittsburgh School of Nursing
Annual Student Health Form

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)

NAME: _____/_____/ _____
(LAST NAME) (FIRST NAME) (Middle Initial)

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

TELEPHONE: _____ E-MAIL: _____

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: 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
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 III: EXAM EVALUATION AND VERIFICATION/ PROVIDER INFORMATION

(HEALTH CARE PROVIDER TO COMPLETE)

I have obtained a health history, performed a physical examination. 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.