# 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_____ Gender _____
(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** Primary Series (DIP) (In Childhood) | 1. Booster date: ___/_____/ _____ | 2. Primary series completed: Yes_____No _____ Date completed:____/_____/ _____ **(Primary series completed within past 10 years or tetanus 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)** (If it has been over 6 months since the last booster, a new titer is necessary) | 1. Titer Date_____/_____/ _____<br>2. Results: 1) immune_____2) not Immune _____<br>(if NOT immune, current booster date- must be within 6 months)<br>3) Booster Date:_____/_____/ _____<br>If equivocal, Health Care Provider must provide statement and initials: _____<br>**(IF EQUIVOCAL, YOU ARE CONSIDERED TO BE NON-IMMUNE UNTIL ANOTHER TITER PROVES OTHERWISE)** |

| | |
|---|---|
| **RUBELLA**<br>(If it has been over 6 months since the last booster, a new titer is necessary) | 1. Titer Date_____/_____/ _____<br><br>2. Results: 1) immune_____2) not Immune _____<br><br>(if NOT immune, current booster date- must be within 6 months)<br><br>3) Booster Date:_____/_____/ _____<br><br>If equivocal, Health Care Provider must provide statement and initials:<br>_____<br>**(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 ☐<br><br>1. LAST DOSE:_____/_____/ _____<br>**Or**<br>2a. Titer Date_____/_____/ _____<br><br>2b. Results: 1) immune_____2) NOT Immune _____<br>2c. If NOT immune: Booster given or immunization series began:<br><br>Date:_____/_____/ _____ |
| **VARICELLA**<br>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_____/_____/ _____<br><br>1. Vaccine Dose 1 ____/_____/ ____<br><br>2. Vaccine Dose 2 ____/_____/ _____<br>**OR**<br>3a. Titer Date:_____/_____/ ____<br><br>3b. Results: Immune_____NOT Immune ____<br>3c. If NOT immune: Booster given or immunization series began:<br><br>Date:_____/_____/ _____ |
| **MENINGOCCOCAL QUADRIVALENT** (meningitis)<br>**REQUIRED IF LIVING IN UNIVERSITY HOUSING.** TWO DOSES ARE REQUIRED, WITH ONE DOES ADMINISTRATED AT 16 YEARS OLD OR OLDER. | If History of disease, give date_____/_____/ _____<br><br>1. Vaccine Dose 1 ____/_____/ ____<br><br>2. Vaccine Dose 2 ____/_____/ _____<br>**OR**<br>3a. Titer Date:_____/_____/ ____<br><br>3b. Results: Immune_____NOT Immune ____<br>3c. If NOT immune: Booster given or immunization series began:<br><br>Date:_____/_____/ _____ |

**TB Screening: One of the following is required**

| | |
|---|---|
| **1. TUBERCULOSIS SKIN TEST** | 1. Date Read Test: ____/_____/ _____<br>2. RESULT: ☐ POSITIVE ☐ NEGATIVE |
| **2. TUBERCULOSIS QUANTIFERON GOLD BLOOD TEST** | 1. Date Read Test 1:_____/_____/ _____<br>2. RESULT: ☐ POSITIVE ☐ NEGATIVE |
| **CHEST X-RAY**<br>(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:<br>_____/_____/ _____<br>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 |

N**ote: 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.**