



Wilkes University
Department of Nursing
Pearsall Hall - 109. S. Franklin Street - Wilkes-Barre, PA 18766

Health Screening Requirements

In keeping with the rules and regulations of the Pennsylvania State Board of Nursing and health care agencies, each student is **required** to submit the following documents to the Department of Nursing: ATTENTION Lori Drozdis at the *address above* by **June 15th** for students entering in the fall semester, **January 5th** for students entering in the spring semester. **Failure to comply with these deadlines will result in a \$100.00 late fee. This late fee will be strictly enforced. PLEASE NOTE: YOU MUST KEEP A COPY OF ALL OF THESE DOCUMENTS FOR YOUR OWN RECORDS IN CASE YOUR ASSIGNED CLINICAL AGENCY ASKS YOU FOR THEM!!!!**

Please review this form in its entirety and share this checklist with your Health Care Provider:

√	ITEM	DOCUMENTATION
	Completed Student Health Record & Physical Examination THIS IS AN ANNUAL REQUIREMENT !!!	All nursing students are required to have a completed physical examination. It is imperative that the physical exam be current, no later than 6 months prior to the start of the semester. Students must use this form.
	TB Screening - 2-Step Method THIS IS AN ANNUAL REQUIREMENT !!!	A current 2-Step PPD is required . ALL Students MUST have their 2-Step PPD completed prior to the start of clinical. Provide proof of two negative PPD results. Attach PPD results to Student Health Record. PPD results MUST be updated on a yearly basis and be valid through May of each year in order to maintain status in the program, exceptions: <ul style="list-style-type: none"> ✚ Students who have received BCG immunization should not get a PPD ✚ Students who have had a positive PPD ✚ Students who are immunosuppressed, have cancer, or are on steroids should not get a PPD <p>If PPD cannot be obtained, the student should have a SINGLE chest x-ray to document freedom from disease. Thereafter, on a yearly basis, the student must be evaluated by their Healthcare provider for evidence of TB. Attach copy of radiology report to the Student Health Record.</p>
	CPR Credentialing THIS IS AN ANNUAL REQUIREMENT !!!	All nursing students are required to provide proof of current CPR credentialing. Acceptable CPR courses are BCLS for Health Care Providers from the American Heart Association (2-year renewable) or BCLS for Professional Rescuers from the American Red Cross (1-year renewable). Attach copy of CPR card to Student Health Record.
	Liability Insurance THIS IS AN ANNUAL REQUIREMENT !!!	Each student is required to possess professional liability (malpractice) insurance. The Wilkes University Department of Nursing uses a group policy for all students. The cost for this protection is billed to you after the start of each semester. It is approximately \$40.00 per year.
	Student Statement of Release THIS IS AN ANNUAL REQUIREMENT !!!	The Wilkes University Department of Nursing respects the confidentiality of the student's health information and is required by law to protect the student's health information. All student health forms are secured as mandated by the Pennsylvania State Board of Nursing. Disclosure of health information to clinical agencies requires the student's authorization. A signed Statement of Release authorizes Wilkes University's Department of Nursing to disclose health information to clinical agencies and/or to contact the student's Healthcare Provider for clarification of information.
	Measles, Mumps & Rubella *Done once LAB WORK	Proof of measles, mumps and rubella titers (lab work) are required. Attach titer reports to Student Health Record. The MMR titers once determined do not have to be rechecked. If the rubella titer is negative, a follow-up rubella booster must be given. Six (6) months following booster, a new titer is required.
	Hepatitis B Review annually	Proof of Hepatitis B Surface Antibody titer (lab work) is required. Attach titer report to Student Health Form. Exceptions: <ul style="list-style-type: none"> ✚ History of Hepatitis B disease - Attach copy of Anti-HBc positive report ✚ Hepatitis B declination - Attach signed waiver ✚ Incomplete Hepatitis B Series immunization - Attach signed Incomplete Hepatitis B Series Vaccine form ✚ Dates of immunization are required. Complete page 4 of this form.
	Varicella/Chicken Pox *Done once LAB WORK	Proof of Varicella titer (lab work) is required. Attach titer report to Student Health Form.
	Tetanus Review annually	Date of last booster. Must be within last 10 years. *Fill in date on page 3.
	Criminal Background Check *Done once, unless a change	All students are required to submit a criminal background check. Attach a copy of the criminal background check to the Student Health Record. Please follow the instructions on http://www.certifiedbackground.com/ to obtain your clearance: *USE THE FOLLOWING PACKAGE CODES: IF YOU LIVE OUT OF STATE: IK91a; IF YOU LIVE IN PENNSYLVANIA USE: IK91 <ul style="list-style-type: none"> • Log on to http://www.certifiedbackground.com/ CLICK ON "STUDENTS"
	Child Abuse History Clearance *Done once, unless a change	All students are required to submit a Pennsylvania Child Abuse History Clearance. Attach copy of child abuse clearance to the Student Health Record. Please follow the <u>Pennsylvania Child Abuse History Clearance</u> procedure for obtaining your clearance: <ul style="list-style-type: none"> • Log on to http://www.dpw.state.pa.us/General/FormsPub/003671038.htm



Student Health Record

for Academic Year 20 ____

Check class level in nursing program:

- Sophomore
- Junior
- Senior
- Transfer: Level _____
- Traditional Master's Program
- Professional Master's Program

Student's Statement

Win Number#

Student's Name: (Last)	(First)	(MI)	Date of Birth:	Gender:
Address: (Street)				
(City)	(State)	(Zip Code)	Home Phone: () ()	Email Address:
Name and Relationship of Emergency Contact: (Name)			(Relationship)	
Address and Phone Number of Emergency Contact: (Address)			(Phone Number)	

Personal Health History

	Yes	No		Yes	No		Yes	No	
1.			AIDS or HIV Infection	23.		Frequent indigestion	45.		Mononucleosis
2.			Anemia	24.		Gallbladder Disease	46.		Mumps
3.			Anorexia/Bulimia	25.		German Measles	47.		Palpitations
4.			Anxiety/Panic Disorder	26.		Glaucoma	48.		Peptic Ulcer Disease
5.			Arthritis	27.		Gum or Tooth Trouble	49.		Physical Disability
6.			Asthma	28.		Head Injury with LOC	50.		Pneumonia
7.			Autoimmune Disease	29.		Heart Disease	51.		Polio
8.			Back trouble	30.		Heart murmur	52.		Recent weight change
9.			Bladder Infections	31.		Hemorrhoids	53.		Recurrent Diarrhea
10.			Bleeding Disorder	32.		Hepatitis	54.		Rheumatic Fever
11.			Bronchitis	33.		Hernia	55.		Rupture (hernia)
12.			Cancer/Tumor/Cyst	34.		Hives	56.		Scarlet Fever
13.			Chest discomfort	35.		Hypertension	57.		Sinusitis
14.			Chicken pox/Shingles	36.		Insomnia	58.		Skin problems
15.			Chronic Cough	37.		Intestinal Disease	59.		STD/VD
16.			Diabetes	38.		Kidney Disease/Stones	60.		Smallpox
17.			Depression	39.		Learning Disability	61.		Stroke
18.			Diphtheria	40.		Liver Disease/Jaundice	62.		Thyroid Disease
19.			Dizziness/Fainting	41.		Loss of limb	63.		Tuberculosis/+PPD
20.			Drug/Alcohol Problem	42.		Measles	64.		Urinary Tract Infection
21.			Epilepsy/Seizures	43.		Migraine Headaches	65.		Weakness/Paralysis
22.			Fractures	44.		Mitral Valve Prolapse	66.		Other:

COMMENT ON ALL "YES" ANSWERS:

- A. Has your physical activity been restricted during the past five years? YES NO
If YES, Explain (providing reasons and durations):
- B. Do you have allergies? YES NO
If YES, specify (food, medication, latex, other):
- C. Do you take medications (prescribed, OTC, herbals, vitamins) regularly? YES NO
If YES, specify medication and reason taken:

I certify that the information contained on this form is true and correct. I understand that misrepresentation or omission of information is sufficient grounds for dismissal from the nursing program

Student Signature _____

Date _____



Physical Examination Form

TO THE HEALTHCARE PROVIDER: Please review the student's health history, acknowledge the review, and complete the physical exam form. Please comment on all negative findings. This information is strictly for the use of the Wilkes University Department of Nursing and will not be released without the student's consent. The student has been academically accepted into the nursing program. Only if it is deemed that the student has some physical or emotional disability that will not allow for the completion of the nursing curriculum will this information affect the student's status. Please administer the required immunizations and order the required laboratory titers or radiological tests (e.g., single chest x-ray).

Physical exam must be completed within SIX (6) MONTHS of the academic year.

Height: _____ Weight _____ Date of last tetanus booster _____ (must be within 10 yrs)

Temperature: _____ Pulse: _____ Respirations: _____ Blood Pressure: _____ / _____

A. Is student FREE from communicable disease? YES NO

B. Is the student free from signs and symptoms of TB? YES NO

Comment on any "NO" answers: _____

REVIEW OF SYSTEMS

	Normal	Abnormal	Notes: Describe abnormality
1. Skin	<input type="checkbox"/>	<input type="checkbox"/>	
2. EENT	<input type="checkbox"/>	<input type="checkbox"/>	
3. Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	
4. Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	
5. Musculo-Skeletal	<input type="checkbox"/>	<input type="checkbox"/>	
6. Metabolic/Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	
7. Neuropsychiatric	<input type="checkbox"/>	<input type="checkbox"/>	
8. Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	
9. Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	
10. Spine/Gait	<input type="checkbox"/>	<input type="checkbox"/>	
Visual Acuity: (SNELLEN) <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL Describe:			Gross Hearing: <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL Describe:

C. Is this student currently under treatment for any medical or emotional condition? YES NO

D. Are there any limitations for physical activity (e.g. Patient care)? YES NO

E. Are there any physical/psychiatric reasons why this student should not participate in patient care? YES NO

Comment on any "YES" answers: _____

Printed Name of Healthcare Provider: _____ Date of Exam: _____

Healthcare Provider Signature: _____

Healthcare Provider Address: _____

Healthcare Provider Phone Number: _____



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FORM FOR COMPLETE HEPATITIS B SERIES VACCINE

I have received the following doses of the Hepatitis B Vaccine:

Dose 1: Date: _____ **Dose 2:** Date: _____ **Dose 3:** Date: _____

 Signature

 Date



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FORM FOR DECLINATION OF HEPATITIS B VACCINE

I understand that as part of my clinical experiences as a nursing student, I may be exposed to blood or other potentially infectious materials and that as a result, I may be at risk of being infected by the Hepatitis B virus. I understand that Hepatitis B is a severe and potentially life-threatening illness and that taking the series of three vaccinations would significantly reduce my risk of being infected by the Hepatitis B virus. Nevertheless, I elect not to take the required series of vaccinations and assume responsibility for all arrangements, costs, and complications arising from not taking the Hepatitis B Vaccine Series. I also understand that if the hospital or clinical agency where I have been assigned for my clinical requires students to be immunized for Hepatitis B, the Wilkes University Department of Nursing assumes no responsibility for reassigning me to another clinical agency, and therefore, I will not be able to take the required course.

 Signature

 Date



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WAIVER FORM FOR INCOMPLETE HEPATITIS B SERIES VACCINE

I have started, but not completed or just completed the Hepatitis B Series vaccine. I understand that as a part of my clinical experiences as a student, I may be exposed to blood or other potentially infectious materials and therefore may be at risk of being infected by the Hepatitis B virus. I understand that this waiver is valid only until the date that my series is complete. I agree to provide the Director of Experiential Nursing with immunization verification immediately upon completion of the series.

I have received the following doses of the Hepatitis B Vaccine:

Dose 1: Date: _____ **Dose 2:** Date: _____ **Dose 3:** Date: _____

 Signature

 Date



STUDENT STATEMENT OF RELEASE

Prior to participation in any clinical experiences, I understand that I must submit a completed Student Health Record, Physical Examination form, and proof of required immunizations. I hereby authorize Wilkes University Department of Nursing to release my health information to clinical agencies upon their request and/ or to contact my Healthcare Provider for clarification of information.

I am aware that if during the course of the academic year my health status should change in a way that would impact my ability to perform in clinical, I must notify the Department of Nursing Chairperson. The need for additional clearance will be determined at that time.

Student Name (Please Print)

Student Signature

Date



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Attach 2 step PPD results or Copy of Chest X-Ray here:



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Attach copy of CPR card here:



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Attach copy of Measles, Mumps, Rubella, & Varicella titers (LAB WORK) here:



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**Attach copies of *child abuse* and *criminal background* clearances to the back of this form.
Keep original form for your file.**

*** Child abuse clearance is sent directly to you in the mail. This often takes 2 to 4 weeks.

*** Criminal background clearance must be printed out upon completion.