University of Lynchburg

Congratulations on your admission to the **Nursing Program** at the University of Lynchburg.
This document is the **Health Information Form**. Complete this form, using ***black ink***, providing accurate and honest information. University of Lynchburg Nursing will use this information to see that you are meeting the health requirements of the clinical agencies you attend for your clinical learning experiences. Immunization and Tuberculosis Testing requirements are based on current CDC (Centers for Disease Control and Prevention) recommendations for healthcare providers. Additionally, many clinical agencies require students to complete a physical exam.

The **Health Information Form** consists of:

- Medical History (Part A). To be completed by the student.
- Immunization Record (Part B). To be completed by your health care provider.
- Physical Health Evaluation (Part C). To be completed by your health care provider.
- Tuberculosis Screening Questionnaire (Part D). To be completed by your health care provider.
- Tuberculosis Testing (Part E). To be completed by your health care provider.
- Management of Positive Tuberculosis or IGRA. (If determined necessary by your health care provider.)
- Release of Information. To be completed and signed by the student.

TO DO LIST:

- Complete and sign the Medical History and Release form.
- Write your name on each page of this form.
- Take the Immunization Record, Physician Health Evaluation and Tuberculosis Screening Questionnaire to your health care provider and have him/her complete and sign.
- Attach/upload any pertinent diagnostic study results ex. lab, x-ray.
- Upload as instructed to the CastleBranch.com website. Instructions will be provided by University of Lynchburg Nursing on how to access and create an account with CastleBranch.

For Summer Entry/2nd Degree students only:

- Your physical exam needs to be completed within the same calendar year you begin the program.

University of Lynchburg

Nursing Program
Student Health Information and Physical Form

This Health Information Form is *required* for all **University of Lynchburg** nursing students. Please complete this form, using *black ink*. Complete Part A, then take this ENTIRE form to your health care provider for completion of Parts B, C, D, and E. Please write you name on each page of this form.

PART A MEDICAL HISTORY

Last Name (please print) First Name Middle Name Last 4 digits of Social Security Number

Home Address City or Town/State Zip Code Phone Number

DOB: _____Gender:_____Marital Status: _____

Family Physician's Name _____ Address_____

Phone Number _____

INSURANCE
All nursing students are required to have health insurance coverage while attending Lynchburg College.

Insurance Company ID/Group# Individual/Employee ID#

MEDICAL CONDITIONS
List all major medical conditions.

MEDICATIONS
List medications (prescription and over the counter)

ALLERGIES
Do you have any allergies to medications?_____Yes _____No Specify:_____

Other Allergies:_____

PART A MEDICAL HISTORY (continued)

PERSONAL HISTORY: **CHECK IF YOU EVER HAD ANY OF THE FOLLOWING:**

____ Cancer	___Headaches/Migraines	___Thyroid Disorder
____ Heart Murmur	___Head Injury/Concussion	___Diabetes
____ Excessive Fatigue with Exercise	___Back/Joint Injuries	___Irritable Bowel/Colitis/Chron's
____ Chest Pain/Discomfort with Exertion	___Broken Bones	___Stomach Ulcers
____ Unexplained Fainting/Near Fainting	___MRSA Infection	___Hepatitis
____ High Blood Pressure	___Arthritis	___Recurrent Bladder Infections
____ Asthma/Bronchitis/Pneumonia	___Anxiety/Depression	___Kidney Problems
____ Frequent Colds/Sinus Infections	___Mental Health Issues	___Menstrual Problems
____ Ear Infections/Hearing Loss	___ADD/ADHD	___Abnormal Pap Test
____ Mononucleosis	___Drug Addiction/Alcoholism	___Pelvic Infections/STD's
____ Anemia/Blood Disorder	___Sexual Assault/Abuse	___Epilepsy/Seizure Disorder
____ Sickle Cell Trait	___Eating Disorder	___Chicken Pox (titer required)
____ Dizzy/Fainting Spells	___Obesity	___Other

Details of above: _____

_____

1. Do you have a physical disability?_____If yes, explain any special services needed _____

_____

2. Have you ever had a serious illness, injury or operation not listed above?_____Explain _____

_____

3. Have you ever had an overnight hospital admission?_____If yes, give date and reason _____

_____

FAMILY HEALTH HISTORY

INDICATE ANY PRESENT OR PAST HEALTH CONDITION IN PARENTS, SIBLINGS, or CHILDREN:

ILLNESS	FAMILY MEMBER	ILLNESS	FAMILY MEMBER
____ Death before age 50	_____	Diabetes/Thyroid Dz	_____
____ Hypertension	_____	Seizure/Neurological Disorder	_____
____ Cancer	_____	Asthma	_____
____ Stroke	_____	Anxiety/Depression	_____
____ Tuberculosis	_____	Alcohol/Drug Problems	_____
____ Sudden death	_____	Specific Heart Conditions	_____

Does anyone in your immediate family suffer from <u>other</u> serious health problems? Y/N

_____

Number of siblings_____List deceased parents and siblings with cause of death _____

_____

I certify that the information I have provided on this form is truthful, accurate and complete to the best of my knowledge. I understand it is intended for and will be used only by the Lynchburg College Nursing Department to confirm clinical clearance and will be maintained as confidential information.

Signature of Student_____ Date_____

PART B IMMUNIZATION RECORD

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER

REQUIRED IMMUNIZATIONS/TITERS**/Date

A) MMR (Measles, Mumps, Rubella)** → Dose #1_____/____/_____

Two doses live vaccine at or after 12 months of age, at least one month apart → Dose #2_____/____/_____

B) DIPHTHERIA/PERTUSSIS/TETANUS (**Tdap**) → **Booster within last 10 years**_____/____/_____

C) MENINGOCOCCAL VACCINE: → Dose #1_____/____/_____

Booster on or after 16th birthday Booster_____/____/_____

D) HEPATITIS B VACCINE → Dose #1_____/____/_____

3 vaccine series or TITER** → Dose #2_____/____/_____

→ Dose #3_____/____/_____

OR a Hepatitis B Surface Antibody level_____ □**Neg** □**Equivocal** □**Pos** Date _____/___/_____

E) VARICELLA VACCINE or TITER**

Two doses of vaccine one month apart → Dose #1_____/____/_____

→ Dose #2_____/____/_____

Mo Day Yr

OR VZV IgG Titer results_____ □**Neg** □**Equivocal** □**Pos** → Date _____/____/____

F) INFLUENZA VACCINE- **required annually for Nursing majors** ----------▶ Last dose_____/____/_____

***Medical Exemption (Reason)**

☐Transcribed records of student ☐ Vaccine(s) given to student

➠**Verified by :**

Health Care Provider's Signature _____

Name Printed _____

Address _____

_____

Phone _____

_____

Date _____

POSITIVE BLOOD TITERS MUST BE SUBMITTED AS PROOF OF DISEASE IMMUNITY
IF VACCINATION DATES ARE UNAVAILABLE or NOT INDICATED
Please attach pertinent records

***PLEASE ATTACH ANY PERTINENT RECORDS (special tests, labs, specialists' letters, etc.)**

PART C PHYSICAL HEALTH EVALUATION

MUST BE COMPLETED IN FULL, SIGNED AND DATED BY EXAMINING PHYSICIAN, NP, or PA

Note to examiner: This student has been admitted to the University of Lynchburg Nursing Program. Please review the student's medical history (Part A) and complete this form, commenting on all positive answers. The information will be used to confirm that this student can safely perform in the clinical setting. No information will be released without the student's written consent.

Pulse_____ Blood Pressure_____Height (in)_____Weight (lbs)_____BMI_____

PHYSICAL EXAMINATION Findings:

HEENT	
RESPIRATORY	
CARDIOVASCULAR	
GENITOURINARY	
GASTROINTESTINAL	
MUSCULOSKELETAL	
METABOLIC/ENDOCRINE	
NEUROLOGICAL	
SKIN	

***PLEASE ATTACH ANY PERTINENT RECORDS (special tests, labs, etc.)**

Has the student ever been treated for an emotional, behavioral, or psychological condition (including eating disorders and/or substance abuse)?_____No_____Yes Explain_____

_____

Is the student currently under treatment for any medical/psychological condition?_____No_____Yes Explain, including recommendations for follow-up_____

_____

Does this student require any dietary modifications?_____No____Yes_____Specify _____

Has the student ever been diagnosed with MRSA?_____No____Yes/Date _____

List any medications the student is taking:_____

➡ **PERMISSION FOR NURSING CLINCIAL PARTICIPATION**

Must mark one of the following:

RESTRICTED ACTIVITY_____No_____Yes

If yes,
Explain restrictions_____

DATE _____

MD/NP/PA SIGNATURE _____

PRINTED:

NAME _____

ADDRESS _____

_____

PHONE _____ FAX _____

PART D TUBERCULOSIS SCREENING QUESTIONNAIRE

Date of Screening _____

	(Circle)	
A. Has Pt ever had a positive reaction to a TB skin test? *Documentation of results, chest x-ray, and treatments required	No	Yes*
B. Does Pt have any of the following signs or symptoms of active TB disease? (Circle)		
Fever	No	Yes
Unexplained weight loss	No	Yes
Loss of appetite	No	Yes
Night sweats	No	Yes
Chronic cough	No	Yes
Coughing up blood	No	Yes
Chest pain	No	Yes
C. Do any of these high-risk categories apply to Pt? (Circle)		
Current Nursing major	No	Yes
Risk for HIV infection	No	Yes
Recent contact with someone infected with TB	No	Yes
History of illicit drug use	No	Yes
Resided or worked in homeless shelter, prison, nursing home, hospital, or other health care facility	No	Yes
History of silicosis, diabetes, renal disease, blood disorders or cancer	No	Yes
Low body weight	No	Yes
Gastric bypass	No	Yes
Prolonged corticosteroid or other immunosuppressive therapy	No	Yes
Within the past 5 years traveled to or lived in any country where TB is endemic (e.g., Africa, Asia, Eastern Europe, or Central or South America)	No	Yes
Have travelled to any of these countries in the last year: <u>If yes, circle destination(s)</u>	No	Yes

Angola Bangladesh Brazil Cambodia China Congo Central African Republic DPR Korea DR Congo Ethiopia India Indonesia Kenya Lesotho Liberia Mozambique Myanmar Namibia Nigeria Pakistan Papua New Guinea Philippines Russian Federation Sierra Leone South Africa Thailand the United Republic of Tanzania Viet Nam Zambia Zimbabwe (High Burden TB Country List by WHO 2016-2020)

Reviewed by_____
Please indicate credentials

IMPORTANT: A positive TB test indicates that you have been exposed to/infected with the TB bacteria. It does not indicate that you have latent TB, active TB disease, or that you are contagious. A CXR and possibly a sputum specimen may be needed to confirm the state of infection. There is also the potential for a false positive test.

In order to participate in the clinical setting, students with a previous history of a positive TB test must present results of a CXR done within the previous 1 year of admission to the Lynchburg College Nursing program. Annually, a TB Screening Questionnaire must be completed (this form).

A student who presents documentation of a completed course of treatment for latent TB infection or active TB infection should complete the TB Screening Questionnaire with initial immunization screening and then annually.

A student who has a new, positive TB test while in the LC Nursing program must get a CXR. The TB Screening Questionnaire must then be completed annually.

A CXR should be obtained any time a student demonstrates symptoms of active TB disease for more than 3 weeks in duration. A sputum specimen for culture may be obtained also.

PROCEED TO THE NEXT PAGE- PART E TUBERCULOSIS TESTING

PART E TUBERCULOSIS TESTING

Proceed to option **A OR B below**.

Option A: Tuberculin Skin Test (TST): Preferred test for most clinical sites rather than IGRA

A one-time 2 step TST is required for all incoming students to the University of Lynchburg nursing program. Documentation of a TST placed and read within the past 12 months may be used as step 1 of the 2 step process.

A 1 step TST must be completed yearly thereafter while in the LC nursing program.

Step 1: Required for the 1 step TST and as step 1 of the one-time 2 step TST

PPD (Mantoux) 0.1 ml (5TU) intradermal left/right forearm Lot #_____ Exp. Date_____

Date administered_____ **Time**_____ **placed by**_____
Please indicate credentials

Date read_____ Time_____ (48-72 hours after 1st placement)

Result_____ **mm of induration** **Negative**____ ***Positive** ____ **read by** _____
Please indicate credentials

Step 2: Required as step 2 of the one-time 2 step TST

PPD (Mantoux) 0.1 ml (5TU) intradermal left/right forearm Lot #_____ Exp. Date_____

Date administered ____/__/____ Time _____ **placed by**_____
Please indicate credentials

Date read __/____/__ **Time** _____ (48-72 hours after 2nd placement)

Result_____ **mm of induration** **Negative**____ ***Positive**____ **read by** _____
Please indicate credentials

Option B: Blood Assay for M. Tuberculosis (BAMT) test-
(Recommended for international students)

Interferon Gamma Release Assay (IGRA) **Date blood drawn** _____

Please attach results: Negative_____ **Positive**_____

CXR result documentation is required if Interpretation is ever *Positive* CDC. Guidelines for preventing the transmission of *Mycobacterium tuberculosis* in health-care settings, 2005. MMWR 2005;54(No. RR-17).

ATTENTION HEALTH CARE PROVIDER: See next page if positive TST or BAMT

Management of Positive TST or IGRA

All students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- ❑ Infected with HIV
- ❑ Recently infected with *M. tuberculosis* (within the past 2 years)
- ❑ History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- ❑ Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- ❑ Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- ❑ Have had a gastrectomy or jejunoileal bypass
- ❑ Weigh less than 90% of their ideal body weight
- ❑ Cigarette smokers and persons who abuse drugs and/or alcohol

••Populations defined locally as having an increased incidence of disease due to *M. tuberculosis*, including medically underserved, low-income populations

____Student agrees to receive treatment

____Student declines treatment at this time

Health Care Professional Signature	Date
Street Address	Phone
City/State Zip Code	Fax

RELEASE OF INFORMATION

I, _____, give permission to University of Lynchburg Nursing's Clinical Coordinator to release a copy of my Immunization Record, TB Screening, physician's health recommendations, background check, and/or drug screen results to a clinical agency only as requested and appropriate. This does not include permission to share information otherwise. The Nursing Department's Clinical Coordinator will have access to the student's health information only for the purpose of confirming that this student is/is not meeting clinical requirements. A copy of this information will be stored on a secure-password protected site (CastleBranch.com).

I understand that this authorization shall remain effective until revoked by written request.

_____

Print Name

_____

Signature of Student

_____

Date