

INITIAL HEALTH EVALUATION FORM: RMU DNP PROGRAM

Student Name: _____

Address: _____

Phone Number: _____

Instructions for Completion of Initial Health Evaluation Form for RMU DNP Program

Directions for the Healthcare Provider (Physician, Nurse Practitioner, Physician Assistant)

- Perform a health history and a complete physical exam.
- Fill out the health evaluation form completely.
- Record all requested information directly onto this form.
- Attachments, such as lab reports, copies of immunization records, etc., are not an acceptable substitution for completion of this form.
- Titers are required as indicated on the form.
- Immunizations should be up-to-date as recommended by the CDC.
- Required PPD is Mantoux type and is considered valid for one year.
- Signature of healthcare provider/examiner with date is required on the form.
- Placement of the official stamp of the examiner on the form where designated is required.

Directions for the RMU DNP Student

- The DNP student is responsible for the correct completion of the health form.
- Return of the health form to the DNP Coordinator (Lynn Gaydosik) by the given due date is required.
- Incomplete forms will be returned.
- Additions made by the healthcare provider on returned forms must be initialed or signed.
- Complete up-to-date health evaluations are an ongoing requirement for clinical.
- Annual health updates are due after the initial health evaluation while in the DNP Program.
- The DNP student must sign and date the "Clinical Agency Permission."
- The DNP student must sign and date the "Student's Health Insurance Agreement."
- The DNP student must sign and date the "Hepatitis B Declination," if applicable.

Initial Health Evaluation Form: RMU DNP Program

Student Name: (please print) _____

Completion by Physician/Nurse Practitioner/Physician Assistant

Immunizations			
Immunization	Completed Series		
DTaP/TD	<input type="checkbox"/> Yes <input type="checkbox"/> No	TD/Tetanus within last 10 years: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: ____/____/____
Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Booster: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: ____/____/____
MMR	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dates: ____/____/____ ____/____/____ ____/____/____	Born before 1957 with history of disease? <input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dates: ____/____/____ ____/____/____ ____/____/____	"Hepatitis B Declination" must be signed by DNP student if not immunized for Hepatitis B.
Meningitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: ____/____/____	Waiver must be signed by resident student and be on file in RMU Office of Health Services if not immunized for Meningitis.

Required Titers		
Date of Titer	Titer Results	Action
<i>Rubeola</i> (Measles) <i>Titer Required</i> Date of Titer: ____/____/____	<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune	If non-immune, vaccine is required. Dates: ____/____/____ ____/____/____
<i>Mumps</i> <i>Titer Required</i> Date of Titer: ____/____/____	<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune	If non-immune, vaccine is required. Dates: ____/____/____ ____/____/____
<i>Rubella</i> (German Measles) <i>Titer Required</i> Date of Titer: ____/____/____	<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune	If non-immune, vaccine is required. Dates: ____/____/____ ____/____/____
<i>Varicella</i> (Chicken Pox) <i>Titer Required</i> Date of Titer: ____/____/____	<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune	If non-immune, vaccine is required. Dates: ____/____/____ ____/____/____

PPD (TB Testing)	
Date of administration: ____/____/____	Date read: ____/____/____
Administered by: _____	Read by: _____
Lot # _____ Exp. Date: _____	Results: ____ Negative ____ Positive ____ mm
<u>If positive:</u>	
Chest x-ray Date: _____	Results: ____ Normal ____ Abnormal
Treated for positive PPD: ____ Yes ____ No	
Treatment: _____	Start Date: _____ Duration: _____

Initial Health Evaluation Form: RMU DNP Program

Student Name: (please print) _____

Completion by DNP Student in the RMU DNP Program

Clinical Agency Permission: (Select one option, sign, and date)

____ I give permission to release my medical information to the course-related clinical agencies.

____ I do not give permission to release my medical information to the course-related clinical agencies.

Students who decline permission to release medical information to course-related agencies may be limited in clinical experience options.

Signature of Student: _____ Date: _____

Student's Health Insurance Agreement: (Sign and date)

I verify that I am covered by health insurance. I agree to maintain health insurance coverage throughout the DNP 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.

Signature of Student: _____ Date: _____

Hepatitis B Declination: (Sign and date, if applicable)

I understand that due to occupational exposure to blood or other potentially infectious materials I may be at risk for acquiring Hepatitis B Virus (HBV) infection. I have been encouraged to be vaccinated with the HBV vaccine to eliminate or reduce the risk of acquiring HBV. I understand that lack of immunization to HBV may limit my clinical experiences, since some clinical agencies require students assigned to their facilities to be immunized against Hepatitis B.

I have not been immunized against HBV and choose not to have the vaccine.

Signature of Student: _____ Date: _____

It is the ongoing responsibility of the student to inform the School of Nursing of any significant changes in his/her health status.

Academic action, which may include removal from clinical, may be incurred if there has been deliberate misrepresentation of information in any manner on this healthcare form.