Student Name:_____ **Student TLU ID:**_____

TEXAS LUTHERAN UNIVERSITY
NURSING

TEXAS LUTHERAN UNIVERSITY- DEPARTMENT OF NURSING
ANNUAL HEALTH APPRAISAL AND CLINICAL REQUIREMENTS FORM

The Department of Nursing, Texas Lutheran University, in keeping with the rules and regulations of the State Board of Nursing and healthcare agencies, requires all students to complete certain health screening procedures. If you have any questions relating to the requirements, please call the Nursing Program at 830-372-6314.

THIS HEALTH FORM MUST BE COMPLETED BEFORE STUDENTS CAN START CLASSES EACH SEMESTER.

BSN Students will be required to submit an Annual Health Appraisal Form each semester prior to enrollment in courses. Use of other health evaluation forms (e.g. work physicals, etc.) will not be accepted. Please check the health form for completeness before submitting it to the Department of Nursing office and make a copy of the form for your records. Hand-carry or send completed form to:

Texas Lutheran University
Department of Nursing
1000 W. Court Street
Seguin, Texas 78155

Please print unless otherwise indicated. All Date Fields required by this form must be legible and completed with Month, Day and Year values. Failure to comply with these requirements will prevent your enrollment in the upcoming semester.

DISABILITY INFORMATION

If you have a health problem that may require individualized disability services, it is your responsibility to contact the Director of Counseling and Disability Services, 830-372-8009.

HEALTH INSURANCE INFORMATION

ATTENTION: ALL TLU NURSING STUDENTS

You must carry and be prepared to show evidence that you have current health insurance. This is a requirement for the entire duration of your nursing program. This health insurance must cover you for any treatments related to bloodborne pathogens, other potentially infectious materials and any illness or injury that could occur during class or clinical.

I verify that I carry, and will carry for the duration of my program, health insurance that satisfies the requirements of my program and will provide a current copy as proof of my insurance coverage. **(Attach proof of insurance to this form)**

_____ _____

(Student Signature) (Date: Month/Day/Year)

PART I: STUDENT INFORMATION

Date of Birth: _____ Gender (Indicate One): Male / Female / Prefer not to answer
(Month/Day/Year)

Student Phone: _____ (Cell / Home) Okay to leave messages? Y / N Okay to Text? Y / N

Emergency Contact Person: _____ Relationship to Student: _____

Contact Phone Number: _____ Okay to leave messages? Y / N

PART II: IMMUNIZATION/VACCINATION HISTORY

Please refer to the most current CDC guidelines for healthcare personnel and **attach a copy of the schedule of your full immunization history** to include serological testing /titers /laboratory results as appropriate. **Please attach ALL serological testing with levels and ability to reference immunity status.**

Non-Immune status will require additional documentation of updated vaccine and/or series as well as updated serological test results after immunization(s) received. Please refer to most current CDC guidelines for healthcare personnel for more information. (IF EQUIVOCAL, you are considered to be NON-IMMUNE until another titer proves otherwise)

HEPATITIS B:

HEPATITIS B SURF AB QUANT TITER
Please attach ALL serological testing with levels and ability to reference immunity status.
TITER DATE: _____ RESULTS (CIRCLE ONE) : IMMUNE / NON-IMMUNE
(Month/Day/Year)

IF NON-IMMUNE, NEW SERIES DATES AND TITER INFORMATION REQUIRED:

VACCINE NAME (Circle One): Heplisav-B (**2 dose series**) Engerix-B (**3 dose series**) Recombivax HB (**3 dose series**)

VACCINE DOSE 1 (Immediately **for all three types**): _____
(Month/Day/Year)

VACCINE DOSE 2 (1 Month after Dose 1 **for all three types**): _____
(Month/Day/Year)

VACCINE DOSE 3 (**Only for** Engerix B or Recombivax HB; 6 Months after Dose 2): _____
(Month/Day/Year)

FOLLOW-UP HEPATITIS B SURF AB QUANT TITER (1 to 2 Months after Last Dose in Series).
Please attach ALL serological testing with levels and ability to reference immunity status.

TITER DATE: _____ RESULTS (CIRCLE ONE): IMMUNE / NON-IMMUNE
(Month/Day/Year)

If non-immune after repeat hepatitis series, no additional vaccines or testing to be done. (A vaccinee who's anti-HBs remains < 10 mIU/mL after two complete series in considered a "non-responder" and no additional testing is required.)

Student Name:_____ **Student TLU ID:**_____

RUBEOLA (MEASLES), MUMPS and RUBELLA (MMR):

Please attach ALL serological testing with levels and ability to reference immunity status.

TITER DATE: _____
(Month/Day/Year)

RUBEOLA (MEASLES) RESULTS (CIRCLE ONE): IMMUNE / NON-IMMUNE

MUMPS RESULTS (CIRCLE ONE): IMMUNE / NON-IMMUNE

RUBELLA RESULTS (CIRCLE ONE): IMMUNE / NON-IMMUNE

IF ANY PART OF MMR RESULTS ARE NON-IMMUNE, NEW MMR SERIES DATES INFORMATION REQUIRED:

VACCINE DOSE 1 (Immediately): _____
(Month/Day/Year)

VACCINE DOSE 2 (28 days after Dose 1): _____
(Month/Day/Year)

No follow-up titer is required, just the two doses documented.

VARICELLA:

Please attach ALL serological testing with levels and ability to reference immunity status.

TITER DATE: _____
(Month/Day/Year)

VARICELLA RESULTS (CIRCLE ONE): IMMUNE / NON-IMMUNE

IF RESULTS ARE NON-IMMUNE, NEW SERIES DATES REQUIRED:

VACCINE DOSE 1 (Immediately): _____
(Month/Day/Year)

VACCINE DOSE 2 (28 days after Dose 1): _____
(Month/Day/Year)

No follow-up titer is required, just the two doses documented.

TETANUS-DIPTHERIA-PERTUSSIS (TDAP):

(STUDENTS MUST HAVE HAD TETANUS BOOSTER ***WITHIN THE PAST 10 YEARS***; REQUIRED BY CLINICAL AGENCY)

PRIMARY SERIES (DtP) COMPLETED IN CHILDHOOD (CIRCLE ONE): YES / NO

BOOSTER DATE:_____

PART III: TB Screening

Include an attached copy of your Tuberculosis Screening to comply with the following guidelines+:

1st Step of 2 Step PPD (Complete Dates and Initial Result)	**2nd Step of 2 Step PPD** (Must be administered between ***ONE (1) to THREE (3) weeks*** after the first PPD test)
Step 1 of 1st Step PPD: Administer Skin Test	**Step 1 of 2nd Step PPD: Administer Skin Test**
Date Administered:	Date Administered:
Step 2 of 1st Step PPD: Results Read and Documented	**Step 2 of 2nd Step PPD: Results Read and Documented**
Date Read:	Date Read:
Results:	Results:

+IF A TWO (2) STEP PPD TEST WAS DONE AND IS DATED WITHIN ONE (1) YEAR, ONLY ONE (1) STEP IS REQUIRED WITH DOCUMENTATION OF THE PREVIOUS TWO (2) STEP PPD RESULTS ON THIS FORM.
(Mantoux required. The second PPD test must be administered between ***ONE (1) to THREE (3) weeks*** after the first PPD test. These tests **CANNOT** be completed in a single visit with the Healthcare Provider)

OR

Tuberculosis (TB) Bloodtest (IGRA): (accepted are QuantiFERON®-TB and T-SPOT®.TB)
Include an attached copy of the blood test administered with results

Date Administered: _____ Date Read: _____ Results: _____

CHEST X-RAY: Complete and Initial Result (attach copy of x-ray results)
ONLY REQUIRED IF TUBERCULIN SKIN TEST IS POSITIVE. After negative CXR, annual TB questionnaire.

X-RAY DATE: _____ RESULTS (CIRCLE ONE): NORMAL / ABNORMAL
(Month/Day/Year)

TB Questionnaire (if applicable): Attach a copy of the completed questionnaire DATE: _____
(Month/Day/Year)

PART IV: Influenza Vaccination

INFLUENZA VACCINATION WILL BE REQUIRED DURING THE FALL SEMESTER- ONE DOSE ANNUALLY FOR SEASON OF THE FALL SEMESTER. PLEASE FILL OUT THE INFORMATION BELOW OR ATTACH A COPY OF YOUR PROOF OF INFLUENZA VACCINATION:

VACCINE MANUFACTURER: _____

VACCINATION LOT NUMBER: _____ EXPIRATION DATE: _____
(MONTH/DAY/YEAR)

DATE ADMINISTERED: _____
(MONTH/DAY/YEAR)

Student Name:_____ **Student TLU ID:**_____

PART V: HEALTH HISTORY AND PHYSICAL EXAMINATION

(MUST BE COMPLETED BY HEALTHCARE PROVIDER)

I have obtained a health history, performed a physical examination, reviewed the student's immunization status, and reviewed the required laboratory tests. In my opinion, this student is in compliance with the current CDC guidelines for healthcare workers and is able to fully participate in the nursing program at Texas Lutheran University.

Yes / No
(Indicate One)

If this student is **NOT** fully able to participate, please comment on any activity limitations here:

_____

_____

PROVIDER NAME:_____ NP / MD / DO / PA
(Provider who completed Health Form) (Indicate One)

SIGNATURE:_____ DATE:_____
(Provider who completed Health Form) (MONTH/DAY/YEAR)

PLEASE ATTACH A COPY OF THE HEALTHCARE PROVDIER'S BUSINESS CARD
OR
LIST OFFICE ADDRESS & PHONE NUMBER: _____

_____

Must Be Completed By Student:

I verify that I have read and understand all the information in this document. I have included a copy of my proof of health insurance coverage and a copy of my full immunization history as defined in this health form. I will fully comply with the current CDC guidelines for healthcare workers for the duration of the nursing program at Texas Lutheran University.

_____ _____
(Student Signature) (Date: Month/Day/Year)