Required Clinical Information

Graduate Nursing

Form Must Submitted to MedaTrax as part of the clinical approval process.

Whitson-Hester School of Nursing Health and Information Form

Name:

_____

FIRST MIDDLE/MAIDEN LAST

T Number:

_____

Email:

_____

Birthdate:

_____

Permanent Address:

_____

STREET CITY STATE/ZIP

Local Address:

_____

STREET CITY STATE/ZIP

Phone:

(_____)_____

Emergency Contact Information

Name: **Relationship:**

_____ _____

Address:

_____

STREET CITY STATE/ZIP

Phone:

(_____)_____

Health History

(Attach a separate sheet if necessary)

Medical/Surgical History

SURGERY **DATE**

☐ No medical/surgical information to provide

Explain any activity restriction during the past year:

☐ No activity restriction information to provide

Explain any particular difficulty with school, studies, or teachers in the past year:

☐ No information regarding difficulty to provide

Student Name: _____

Discuss any need for counseling or treatment for any nervous condition, mental illness, emotional concern(s) or substance abuse during the last five (5) years:

_____

_____

_____

☐ No counseling/emotional treatment information to provide

Explain any chronic conditions that you are managing through medical care:

_____

_____

_____

☐ No chronic condition information to provide

List any prescribed medications you are presently taking:

_____

_____

☐ No prescription medication information to provide

If there is other information of which you think the School of Nursing should be aware, please describe below:

_____

_____

_____

☐ No additional information to provide

Student Name: _____

Immunizations/Test Records

Please provide **DOCUMENTATION OF IMMUNIZATIONS** or **TITER RESULTS** for the items below.

Your first and last name **MUST** be on each page of documentation you provide.

Influenza Vaccine	
Fall Semester	You must provide documentation of administration of the flu vaccine for the upcoming flu season before **October 1st**.
Spring Semester	You must provide proof of administration of the flu vaccine for the current flu season before admission into the nursing program.
THE FLU VACCINE IS MANDATORY FOR ALL STUDENTS ANNUALLY. Waivers for reasons of religious conflicts or severe allergies **ONLY** will be accepted but may affect placement in some facilities.	

TB Skin Test	
2- Step Test	A 2-step test is 2 separate TB skin tests administered at least 1 week but no longer than 30 days apart. You must provide documentation of an **initial 2-step test for admission**.
Annual Test	After the initial 2- step TB skin test, a regular TB skin test (or TB assessment) is required **ANNUALLY**.
Positive Results	If your TB skin test is positive or if it has been positive in the past, documentation of a negative chest x-ray and TB assessment by a health care professional is required for admission. After this initial x-ray and assessment, a TB assessment must be performed and documented **ANNUALLY**.
A TB tine test is NOT acceptable.	

Tetanus, diphtheria, and pertussis (Tdap) Vaccine	
The Tdap vaccine is administered after age 11 as a booster to the DTaP vaccines received during childhood. Documentation of a dose of **Tdap is required**.	
Not Received or Received > 10 years	If you have not received a dose of Tdap, you will need to do so as soon as possible. If your documented dose of Tdap was more than 10 years ago, please provide documentation of your Tdap as well as documentation of any Td or Tdap vaccines (tetanus booster) that followed.
A Tdap vaccine is NOT the same as DTaP or Td vaccines.	

Measles, mumps, rubella (MMR) Vaccine	
You must provide documentation of **2 MMR vaccinations** or **positive titer results**.	
Titer	If you have received the vaccines in the past but cannot provide documentation, titer (blood test) results that show immunity for *each of the three* components [measles, mumps, rubella] will be accepted. If titer results show non-immunity, you will need to provide documentation of 2 MMR vaccinations.
Still Receiving	If you are receiving the MMR vaccines for the first time, you may provide documentation of the first dose, then follow-up with the next dose as scheduled by your health care provider and provide documentation when it is available.
If you have received these vaccinations in the past yet are still found non-immune, please consult your health care provider for suggested treatment.	

Hepatitis B Series	
You must provide documentation of a **completed 3-dose Hepatitis B series** or **positive titer results.**	
Titer	If you have received the series in the past but cannot provide documentation, titer (blood test) results that show immunity will be accepted. If titer results show non-immunity, you will need to provide documentation of 3 Hepatitis B vaccinations.
First Time/Still Receiving	If you have not ever received the Hepatitis B series, start the 3-dose series as soon as possible. If you are receiving the Hepatitis B series for the first time, you may provide documentation of the first dose, then follow-up with the following doses as scheduled by your health care provider and provide documentation when it is available.
If you have completed the series yet are still found non-immune, please consult your health care provider for suggested treatment.	

Varicella Titer	
You must provide documentation of a **varicella titer [including date and result].**	
Titer Results	If the titer shows that you are not immune to varicella, you will be required to provide documentation of 2 varicella vaccines in the past or receive 2 vaccines as scheduled by your health care provider. • Documentation of varicella titer results is **REQUIRED**.
REPORT OF VARICELLA (CHICKEN POX) DISEASE WILL NOT BE ACCEPTED.	

Drug Screen	
A **10-panel drug screen** is required to be completed prior to the start of Nursing School.	
Documentation	Documentation must be **PRINTED** and include the date the test was done, which drugs the student was tested for, results of the tests (positive or negative), and a signature of the provider. **NO** HANDWRITTEN FORMS WILL BE ACCEPTED.
Positive Results	If one or more panels are found positive due to a prescribed medication, the student will be required to submit either a physician's note stating that it is a prescribed medication for the student or provide the prescription bottle which shows the student's name and expiration date of the prescription.
YOU MUST PROVIDE A LIST OF THE DRUGS TESTED FOR IN THE TEST ADMINISTERED.	

CPR Certification	
You are required to present documentation of a valid **Basic Life Support (BLS)** certificate throughout Upper Division Nursing.	
AHA	Certification must be awarded by the **American Heart Association** through an **AHA certified instructor.** A HeartSaver certification will not be accepted, neither will non-AHA sites or non-AHA certified instructors that state they follow AHA guidelines.

Some clinical agencies may require additional tests/immunizations. You will be notified prior to assignment in these agencies.

By signing below, you agree to provide the above immunization and test records to the School of Nursing and to comply with SON requirements regarding maintenance of immunizations. Inability to comply will leave you unable to fulfill requirements for course credits and will prevent enrollment in the Nursing program.

NAME: _____ **DATE:** _____

SIGNATURE: _____

Locations for Testing

There are several agencies locally that will provide the required testing.

- Primary Care Provider
- TTU Health Services
- Fast Pace Clinics
- SatelliteMed
- Walgreen's/CVS
- Health Department

For CPR certification classes, check the AHA website for classes in your area.

REMEMBER: Facilities may change the services they offer at any time. Some facilities may require appointments. Costs vary between facilities and some may not accept insurance.

Acceptable Documentation of Immunizations/Test Records

In order to accept proof of immunizations/test records, the documentation MUST include the following:

REQUIRED ON EACH PIECE OF DOCUMENTATION	YOUR NAME DATE OF SERVICE
Vaccinations (Influenza, Tdap, MMR, Hep B)	Documentation must include proof of which vaccine was administered (i.e. vaccine name)
Test Results (TBST)	Documentation must include proof of which test was administered (i.e. TB skin test) **AND** results of the test
Titer Results (Varicella)	Documentation must include proof of which titer was drawn (i.e. varicella) **AND** results of the titer
Drug Screen	Documentation must include proof of which test was administered (i.e. UDS) **AND** results of the test **AND** a list of the drugs tested for in the test administered **AND** a signature of the provider – **MUST** be computer generated **NO** handwritten forms
CPR Certification	Documentation must include proof of which certification was earned (i.e. AHA BLS) **AND** date of expiration

EXAMPLES OF ACCEPTABLE DOCUMENTATION INCLUDE (BUT ARE NOT LIMITED TO): Vaccination card or booklet record often given in childhood, documentation from health department or PCP, pamphlet given at Walgreens or CVS once vaccine given, copy of CPR certificate or card

Medical Care Coverage and Health Insurance

Students are responsible for all costs incurred related to health problems. Students must show proof of health insurance or sign a waiver stating their responsibility for health care cost should these occur. Some clinical agencies require proof of health insurance.

TTU offers limited student health insurance – see details at http://www.tntech.edu/healthservices/insurance/

Please indicate your insurance status below and sign.

____ I have health insurance and have attached documentation (copies of **front and back** of insurance card).

___ I do not have health insurance. I am aware that I am responsible while for all costs incurred relating to health problems while at TTU.

NAME:_____ **DATE:** _____

SIGNATURE: _____

Health Assessment Agreement

Please Read Carefully:

The School of Nursing reserves the right to require further health assessment by a mutually agreed upon health provider. Because the School of Nursing seeks to provide in as much as possible a reasonably safe environment for its nursing students and their clients/patients, a student may be required, during the course of the program, to demonstrate their physical and/or emotional fitness to meet the essential requirements of the program. Such essential requirements may include freedom from communicable diseases and drug addictions, the ability to perform certain physical tasks, and suitable emotional fitness. Any appraisal measures used to determine such physical and/or emotional fitness will be in compliance with Section 504 of the Rehabilitation Act of 1973 and the Americans With Disabilities Act of 1990, so as not to discriminate against any individual on the basis of handicap.

Read the Following Statement and Sign and Date This Form:

I attest that the information provided on this form is correct and true. I give permission to the School of Nursing to provide required and appropriate information from this form to any clinical agency to which I am assigned for Clinical Practicum.

NAME:_____ **DATE:** _____

SIGNATURE: _____

RNs Only:

_____	_____	_____	_____	_____
RN TN License #	Exp. Date	Malpractice	Company	Exp. Date

Approved 1/92; Revised 4/92; Revised 5/93; Revised 5/94

Authorization for Release of Student Information and Acknowledgment

AUTHORIZATION FOR RELEASE OF EDUCATION RECORDS

I,_____, authorize Tennessee Technological University ("Tennessee Tech") to disclose any and all necessary education records including necessary personally identifiable information related to health records, background checks, and credential check(s) to the listed entity/person or class of entities/persons for the purposes described below. I understand that by agreeing to this, I am waiving all personal and legal rights to confidentiality and privacy, including rights under the Family Educational Rights and Privacy Act ("FERPA"), 20 U.S.C. § 1232g and 34 C.F.R. § 99.3 and this release will be effective until I revoke it by sending a written notice of revocation to the Lab Coordinator for Whitson-Hester School of Nursing.

The purposes of the disclosure are to provide verification of immunization status, tuberculosis status, negative drug screens, CPR certification, licensure or credentialing, status of background checks.

The entity/person/entities/persons or classes of persons/entities to which information may be released to clinical practice sites including but not limited to hospitals, nursing homes, outpatient clinics, hospice, public health agencies, schools, home health agencies, daycares, etc.

I understand that a hospital, clinic or similar medical treatment facility may exclude me from clinical placement on the basis of a background check or failure to meet their required health information. I further understand that if I am excluded from clinical placement, I will not be able to meet course requirements and/or the requirements for graduation.

NAME:_____ **DATE:** _____

SIGNATURE: _____

Medical Examination – To Be Completed by MD, NP or PA

Name: _____ Birthdate: _____

Blood Pressure: _____ Height: _____ Weight: _____

Notable Findings of Complete Medical Exam:

Any Conditions at Present that May Result in need for Emergency Care:

Health Concerns That Could Interfere with Learning:

Because Tennessee Tech seeks to provide in as much as possible a reasonably safe environment for its health career students and their patients, a student may be required, during the course of the program, to demonstrate his/her physical and/or emotional fitness to meet the essential requirements of the program. Such essential requirements may include the ability to perform certain physical tasks, and suitable emotional fitness. Any appraisal measures used to determine such physical and/or emotional fitness will be in compliance with Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, so as not to discriminate against any individual on the basis of disability.

Any Present Conditions that May Limit Participation in Classroom or Clinical Activities (Please Specify)

_____

_____

_____

_____

_____

_____

_____

Any Additional Comments and Recommendations:

_____

_____

_____

_____

_____

_____

_____

On the basis of this examination and mindful of the note above, in my opinion, the applicant is physically and mentally fit to participate in the nursing program.

_____ _____

Date Signature MD or NP or PA

Phone: _____ Printed Name: _____

Name of Practice: _____

Address: _____

City: _____ State: _____ ZIP: _____