THE INFORMATION CAN BE ENTERED BY THE STUDENT. ALL INFORMATION MUST BE IN ENGLISH. THIS FORM REQUIRES A HEALTH CARE PROVIDER (PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT) SIGNATURE on Page 3.

PART I: STUDENT INFORMATION - (ALL FIELDS MUST BE COMPLETED)

PEOPLE SOFT NUMBER: ______________________ DATE OF BIRTH: ______________________ GENDER: ______________________ (MM/DD/YYYY)

NAME: _____________________________/__________________________/___________________________
          (LAST NAME)            (FIRST NAME)

ADDRESS ____________________________/____________________________________________________________________________________
          (STREET)                          (CITY/STATE/ZIP)

TELEPHONE: _____________________________          PITT E-MAIL: _____________________________

EMERGENCY CONTACT PERSON: _____________________________ CONTACT RELATIONSHIP: ________________

Health Insurance (must be completed by student):
I verify that I carry and will carry for the entire duration of my program health insurance that will cover payment of treatment and follow-up procedures related to bloodborne pathogens, other potentially infectious materials, and any illness or injury that could occur during class or clinical.

____________________________________________________________________________________

STUDENT SIGNATURE          DATE

PART II: Titers are required for the following two diseases, regardless of immunizations

(Health Care Provider to Complete)

**MEASLES (Rubeola)**

Obtain a titer for measles. Note date and results of measles titer.

Date of measles titer: _____ / _____ / _____

Results of measles titer: _____ Immune _____ Not immune

IF you are NOT immune to measles, you are required to obtain a booster for measles. Note date of booster.

Date of measles booster: _____ / _____ / _____

IF it has been over 6 months since the last booster, a new titer is necessary.

IF equivocal, Health Care Provider must provide statement and initials:

(IF EQUIVOCAL, YOU ARE CONSIDERED TO BE NON-IMMUNE UNTIL ANOTHER TITER PROVES OTHERWISE)
RUBELLA

Obtain a titer for rubella. Note date and results of rubella titer.

IF you are NOT immune to rubella, you are required to obtain a booster for rubella. Note date of booster.

IF it has been over 6 months since the last booster, a new titer is required.

Date of measles titer: _____ / _____ / _____
Results of measles titer: _____ Immune _____ Not immune
Date of measles booster: _____ / _____ / _____

If equivocal, Health Care Provider must provide statement and initials:
________________________________________________

(IF EQUIVOCAL, YOU ARE CONSIDERED TO BE NON-IMMUNE UNTIL ANOTHER TITER PROVES OTHERWISE)

PART III: Two-step TB Test requirement

(Health Care Provider to Complete)

Tuberculosis (TB) Test – Yearly requirement (required to complete one of two options for this test)

Option 1: TWO-STEP TB SKIN TEST

Obtain 2 (two) TB skin tests. Note date of readings of both TB skin tests. Second PPD placement must be placed no less than 7 days after first placement

IF you test positive for TB, you are required to have a CHEST X-RAY. Note date and results of chest x-ray.

OR

Option 2: TB QUANTIFERON GOLD BLOOD TEST

IF you test positive for TB, you are required to have a CHEST X-RAY. Note date and result of chest x-ray.

PART IV: Proof of immunizations or titer, if not immunized, is required for the following:

(Health Care Provider to Complete)

TETANUS-DIPHTHERIA Primary Series (DIP) (received in childhood)

Primary series completed? _____ Yes _____ No

Date primary series completed: _____ / _____ / _____

(Primary series completed within past 10 years or tetanus booster within past 10 years)

Date of tetanus booster: _____ / _____ / _____
**Student Name: ________________________________**

### POLIO
Primary Series (DtP)
(Received in childhood)

Was primary series for Polio received?   _____ Yes   _____ No

### HEPATITIS B

Note dates of each dose of the hepatitis B vaccine.

Date of dose #1:   _____ / _____ / _____
Date of dose #2:   _____ / _____ / _____
Date of dose #3:   _____ / _____ / _____

If you have **NOT** had the 3-dose series for hepatitis B, you are required to have a titer drawn. If hepatitis B titer is required, note date of titer.

If titer indicates that you are **NOT** immune to hepatitis B, you are required to obtain a booster for hepatitis B. Note date of booster.

Date of hepatitis B titer:   _____ / _____ / _____
Results of hepatitis B titer:   _____ Immune   _____ Not immune
Date of hepatitis booster:   _____ / _____ / _____

### MUMPS

Note date of last dose of mumps vaccine.

If you did **NOT** receive mumps vaccine, a mumps titer is required. Note date and results of titer.

If titer indicates that you are not immune to mumps, you are required to obtain a booster for mumps. Note date of booster.

If born before 1957, place an X in the box

Date received LAST DOSE of mumps vaccine:   _____ / _____ / _____
Date of mumps titer:   _____ / _____ / _____
Results of mumps titer:   _____ Immune   _____ Not immune
If **NOT** immune: Booster given or immunization series began:
Date:   _____ / _____ / _____

### VARICELLA

If history of chicken pox, list date of disease in section 1.

If you have **NOT** had chicken pox; list dates of vaccine (2 doses required).

If you have **NOT** had either chicken pox or the varicella vaccine, a titer for immunity is required.

If you are **NOT** immune to chicken pox, you are required to obtain a varicella booster or begin the immunization series for chicken pox. Note date of booster.

Date you had chicken pox:   _____ / _____ / _____
Date of varicella vaccine dose 1:   _____ / _____ / _____
Date of varicella vaccine dose 2:   _____ / _____ / _____
Date of varicella titer:   _____ / _____ / _____
Results of varicella titer:   _____ Immune   _____ Not immune
If **NOT** immune: Booster given, or immunization series began:
Date of varicella booster:   _____ / _____ / _____
**MENINGOCCOCAL QUADRIVALENT** (meningitis)

Required if living in university housing. Two doses are required, with one dose administrated at 16 years old or older.

**IF** history of meningitis, list date of disease in section 1.

**IF** you have **NOT** had meningitis; list dates of vaccine (2 doses required)

**IF** you have **NOT** had either meningitis or the meningococcal vaccine, a titer for immunity is required.

**IF** you are **NOT** immune to meningitis, you are required to obtain a meningococcal booster or begin the immunization series for meningitis. Note date of booster.

**PART V: Required Clearances and proof of BLS training**

<table>
<thead>
<tr>
<th>Basic Life Support for Health Care Certification</th>
<th>The American Heart Association (AHA) – Basic Life Support (BLS) for Healthcare Providers certification must be completed before beginning clinical rotations.</th>
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</thead>
<tbody>
<tr>
<td>Proof of current BLS Provider certification</td>
<td></td>
</tr>
<tr>
<td></td>
<td>To find a training center near you, visit the following:</td>
</tr>
<tr>
<td></td>
<td><a href="http://centerem.org/cpr-training/">http://centerem.org/cpr-training/</a></td>
</tr>
<tr>
<td>Clearances</td>
<td>Act 33 – Child Abuse Clearance</td>
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<tr>
<td>Proof of Act 33, Act 34, and Act 73 clearance.</td>
<td>Act 34 – PA Criminal Record Check Clearance</td>
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<td></td>
<td>Act 73 – Federal Bureau of Investigators (FBI) Criminal Record Clearance</td>
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<tr>
<td></td>
<td><strong>See page 6 of document for instructions on how to apply for your clearances.</strong></td>
</tr>
</tbody>
</table>
PART VI: EXAM EVALUATION AND VERIFICATION/ PROVIDER INFORMATION

(HEALTH CARE PROVIDER TO COMPLETE)

I have obtained a health history, performed a physical examination, and reviewed the student’s immunization status and required laboratory tests. In my opinion, this student is able to fully participate in the School of Nursing program:

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

____________________________________________________________________________________

____________________________________________________________________________________

Name: ________________________________________________________________________________

Physician’s Signature: __________________________________________________________________

Date _____/_____/_______

Phone: _____________________________________________________________________________

All paperwork must be completed and uploaded into Project Concert by 5:00pm on Tuesday, September 5, 2023.
How to obtain my clearances:

ACTS 33, 34, 73, clearances [https://www.nursing.pitt.edu/admissions/clearances](https://www.nursing.pitt.edu/admissions/clearances)

- **ACT 33:** Pennsylvania Child Abuse History Clearance application is processed online at: [https://www.compass.state.pa.us/cwis/public/home](https://www.compass.state.pa.us/cwis/public/home)
  
  It is recommended that you apply as: Individual 14 years of age or older who is applying for or holding a paid position as an employee with a program, activity or service, as a person responsible for the child's welfare or having direct contact with children; applying as an employee who is responsible for the child's welfare or having direct contact (providing care, supervision, guidance or control to children or having routine interaction with children) in any of the following in which children participate and which is sponsored by a school or a public or private organization.

  You will receive an email when your results are available. You will need to log back into the website to retrieve results. **PLEASE BE SURE TO KEEP YOUR USERNAME AND PASSWORD IN A SAFE PLACE, YOU WILL NEED THESE TO RETRIEVE YOUR RESULTS.**

- **ACT 34:** Pennsylvania Criminal Record Check is processed online at: [https://epatch.state.pa.us/Home.jsp](https://epatch.state.pa.us/Home.jsp).
  
  - It is recommended to apply as Employee
  
  - A link to the results comes back immediately (in most cases).
  
  - Click on the case number link to obtain the certificate. Save it to your computer and print a copy.

- **ACT 73:** FBI Fingerprint Clearance
  
  **In Pennsylvania** at: [https://www.identogo.com/services/live-scan-fingerprinting](https://www.identogo.com/services/live-scan-fingerprinting)
  
  - When applying through IdentoGo enter your zip code and click on the site where your fingerprints will be processed
  
  - It is recommended that you apply using the DHS SERVICE CODE # 1KG756 --- Employee >=14 Years Contact w/ Children
  
  - Your results will be sent to the mailing address listed on the application, so be sure to use a non-campus mailing address. Please be aware that the results on the Act 73 application can take up to 12 weeks to come back.
  
  - Please check the website above for approved fingerprint scan locations. Locations are updated frequently, as more sites are approved.
  
  - Do not apply through the Department of Education.

  **Outside of Pennsylvania** at: [https://www.fbi.gov/services/cjis/identity-history-summary-checks](https://www.fbi.gov/services/cjis/identity-history-summary-checks)
  
  - Follow option 1, 2, or 3.
  
  - Your results will be sent to the mailing address listed on the application. Please be aware that the results on the Act 73 application can take up to 12 weeks to come back.
  
  - Do not apply through the Department of Education.