University of Pittsburgh at Greensburg - School of Nursing
Annual Health Form – Junior Students

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)

STUDENT IDENTIFICATION NUMBER: ____________________________

NAME: ____________________________/ ____________________________/ ____________________________
(LAST NAME) (FIRST NAME) (Middle Initial)

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

TELEPHONE: ____________________________ E-MAIL: ____________________________

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 (MONTH/DAY/YEAR)

PART II: Required BLS and Clearance due by August 1th

| Basic Life Support for Health Care Certification | The American Heart Association (AHA) – Basic Life Support (BLS) for Healthcare Providers certification must be completed before beginning clinical rotations. An on-line course will not be accepted! To find a training center near you, visit the following: | Act 34 – PA Criminal Record Check Clearance (Excela Requirement) See page of 3 document for instructions on how to apply for your clearance. |
PART III: Annual Health Requirements due by August 1st
(Health Care Provider to Complete)

<table>
<thead>
<tr>
<th>TETANUS-DIPHTHERIA Primary Series (Tdap) (received in childhood)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary series completed? _____ Yes _____ No</td>
<td></td>
</tr>
<tr>
<td>Date primary series completed: _____ / _____ / _____</td>
<td></td>
</tr>
<tr>
<td>(Primary series completed within past 10 years or tetanus booster within past 10 years)</td>
<td></td>
</tr>
<tr>
<td>Date of tetanus booster: _____ / _____ / _____</td>
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</tbody>
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Tuberculosis (TB) Test (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.

| Date of reading of TB test #1: _____ / _____ / _____ |  |
| Result of TB test #1: _____ Negative _____ Positive |  |
| Date of reading of TB test #2: _____ / _____ / _____ |  |
| Result of TB test #2: _____ Negative _____ Positive |  |
| Date of chest x-ray (if required): _____ / _____ / _____ |  |
| Result of chest x-ray: _____ Negative _____ Positive |  |

OR

| Date of reading TB Quantiferon gold blood test 1: _____ / _____ / _____ |  |
| Date of chest x-ray (if required): _____ / _____ / _____ |  |
| Result of chest x-ray: _____ Negative _____ Positive |  |

Medical TB Questionnaire
Please answer the following questions about signs and symptoms of tuberculosis.

- Are you coughing up blood streaked sputum and/or having chest pain while coughing?  
  - Yes  
  - No

- Had you had a productive cough lasting longer than 3 weeks?  
  - Yes  
  - No

- Have you had unexplained weight night sweats, fever, or fatigue?  
  - Yes  
  - No

- Have you had unexplained loss of appetite or weight loss?  
  - Yes  
  - No
PART III: 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: ____________________________________________________

Note: ALL SECTIONS ON THIS FORM MUST BE COMPLETED BEFORE ITS SUBMISSION!

Upon completion, this form should be scanned and uploaded by the student to ProjectConcert by August 1st.

ACT 34: Pennsylvania Criminal Record Check

- Go to the Pennsylvania Access to Criminal History Website: https://epatch.state.pa.us/Home.jsp
- Click “Submit a New Record Check” or if you are already a registered user, log in
- Select “Individual Request”
- Select “Reason” as “Employment” and enter all other information with a red asterisk (*)
- Enter in your information on the next page to submit for a State check – you will enter credit card information after you enter this information
- When you get to “Results” double click on the blue hyperlink titled “Certification Form” near the center of the page. A certified form with results will be displayed in PDF format. Be sure you open the certificate on a computer with a printer
- If your result is “under review” please make sure to check your email frequently for the results to be posted. Print out the Certification Form after you receive this email
- If you have any questions about the Pennsylvania State Police Request for Criminal Record checks form (SP-164), please call: 717-783-9973 or toll free 1-888-783-7972, or contact your Human Resources Generalist
- 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.

Updated: 04.01.2021