Department of Nursing and Allied Health Professions
Indiana University of Pennsylvania

Health History and Physical Examination
Level I (Sophomore) Requirements

Student's Name _____

Student ID Number _____ Birth date _____

Permanent Mailing Address _____

Local Phone Number _____ Permanent Phone Number _____

As a health screening requirement, all nursing students must have a health history and physical examination performed by a nurse practitioner or physician prior to beginning the entry level nursing courses. Specific laboratory tests and immunizations must also be documented. **TITERS FOR VARICELLA AND RUBELLA ARE REQUIRED.** The purpose of these requirements is to assist in maintaining the health of the student.

	Dates completed	Items without dates Require comments.
History and Physical Exam	_____	
Immunizations		
DPT/DTaP/Tdap	_____	
MMR	_____	
Polio	_____	
HBV series*	_____	

*or waiver signed by student is attached.

Titers are required. Vaccination or illness with the disease is not acceptable as proof of immunity.

	Date of titer
Varicella*	
☐ Immune	
☐ Not immune >	_____
Rubella*	
☐ Immune	
☐ Not Immune >	_____

*If not immune on first titer, student must receive Rubella and/or Varicella immunization(s) and be re-titered to verify immunity.

All students are required to have two-step baseline tuberculin skin test. Students with a history of a positive TB skin test may not be required to repeat the testing. Contact Nursing Services at Suites on Maple East or personal physician/nurse practitioner for guidance.

Two-step Tuberculin Skin Test is required (by CDC guidelines for health care providers).

	Date	Results	Signature
Step One:	_____	_____	_____
Step Two:	_____	_____	_____

If skin test is positive, a negative chest X-ray is required. Negative TB skin test (or chest x-ray) must be in effect for entire academic year.

Positive and student is receiving appropriate follow up care: _____

I have completed a health history and physical examination including required titers and immunizations for this student. I verify that the results are acceptable or if not acceptable this student is under the care of a physician and/or nurse practitioner.

Print Health Care Provider's name _____

Health Care Provider's address _____

_____ Phone Number _____

Signature of Health Care Provider _____

Date _____

Note: History and Physical Exam and lab tests completed January 1 to August 1 will be accepted.

PLEASE RETURN THIS FORM TO: **Department of Nursing and Allied Health Professions**
Indiana University of Pennsylvania
210 Johnson Hall
1010 Oakland Avenue
Indiana, PA 15705

DEADLINE: **December 1**

Submission deadline of December 1 MUST BE MET or student will be administratively disenrolled from NURS 211 and 213.

Revised 9/08