

**SHEPHERD UNIVERSITY DEPARTMENT OF NURSING EDUCATION
HEALTH REQUIREMENTS VERIFICATION (HRV)**

STUDENT COMPLETION

FULL NAME (Last, First, MI): _____
 STUDENT ID: _____ BIRTHDATE (MM/DD/YY): _____
 PHONE / CELL: _____ E-MAIL: _____

COMPLETION BY HEALTHCARE PROVIDER (PHYSICIAN OR NURSE PRACTITIONER ONLY)

IMMUNIZATIONS

DPT _____ TETANUS BOOSTER _____ (see instructions) Tdap _____ (see instructions)
 DATE DATE DATE

POLIO & MMR

(MEASLES/RUBEOLA, MUMPS, RUBELLA/GERMAN MEASLES)

1st MMR _____ DATE 2nd MMR _____ DATE POLIO _____ (DATES OF ALL 4 INJECTIONS)

OR IF UNABLE TO VERIFY FOUR POLIO VACCINATIONS & TWO MMR VACCINATIONS, YOU MUST PROVIDE TITER RESULTS.

TITER RESULTS

RUBELLA _____ DATE IMMUNE NOT IMMUNE RUBEOLA _____ DATE IMMUNE NOT IMMUNE
 MUMPS _____ DATE IMMUNE NOT IMMUNE POLIO _____ DATE IMMUNE NOT IMMUNE
 (Type 1, 2, & 3)

IF TITERS SHOW "No Immunity", BEGIN THE IMMUNIZATION PROCESS IMMEDIATELY & AND REPORT TO PROGRAM CLINICAL COORDINATOR.

VARICELLA

(CHICKEN POX)

CHICKEN POX DISEASE _____ DATE **OR** VARICELLA VACCINE _____ DATE

OR IF UNABLE TO VERIFY CHICKEN POX DISEASE OR VARICELLA VACCINATION, YOU MUST PROVIDE TITER RESULTS.

TITER RESULTS

VARICELLA _____ DATE IMMUNE NOT IMMUNE

IF NOT IMMUNE YOU MUST RECEIVE FIRST VARICELLA VACCINATION AND THE SECOND IN 4 WEEKS.

HEPATITIS B

(SERIES OF 3)

1ST INJECTION _____ DATE 2ND INJECTION _____ DATE 3RD INJECTION _____ DATE
 (1 MONTH FROM 1ST) (6 MONTHS FROM 1ST)

OR IF UNABLE TO VERIFY HEPATITIS B INJECTIONS, YOU MUST PROVIDE TITER RESULTS.

TITER RESULTS

HEPATITIS B _____ DATE IMMUNE NOT IMMUNE

OR

STUDENT WAIVER

I have chosen **NOT** to receive the Hepatitis B Vaccine. Through this refusal, I am relieving Shepherd University and its clinical agencies of all responsibility should I be exposed to the Hepatitis B virus as a student.

STUDENT SIGNATURE _____ DATE _____

IMMUNIZATION VERIFICATION

I verify the above named student's immune status as listed.

PHYSICIAN or NURSE PRACTITIONER SIGNATURE _____ DATE _____

ADDRESS OF PRACTICE _____ CITY/STATE _____ ZIP _____ PHONE _____

(CONTINUED ON REVERSE)

PPD TESTING

(1ST PPD MUST BE WITHIN ONE YEAR OF 2ND PPD OR YOU WILL NEED TO COMPLETE "2-STEP", PER INSTRUCTION SHEET)

1 st PPD	_____	_____	<input type="radio"/> POSITIVE	<input type="radio"/> NEGATIVE	Induration (mm) _____
	DATE PLACED	DATE READ			
2 nd PPD	_____	_____	<input type="radio"/> POSITIVE	<input type="radio"/> NEGATIVE	Induration (mm) _____
	DATE PLACED	DATE READ			

FOR POSITIVE RESULTS COMPLETE FOLLOW-UP INFORMATION BELOW.

CHEST X-RAY

_____	_____
DATE	RESULTS
INH? <input type="radio"/> YES <input type="radio"/> NO	ANNUAL CHEST X-RAY RECOMMENDED? <input type="radio"/> YES <input type="radio"/> NO

I verify the above named student's test results as listed.

_____	_____		
PHYSICIAN/NURSE PRACTITIONER SIGNATURE	DATE		
_____	_____		
ADDRESS OF PRACTICE	CITY/STATE	ZIP	PHONE

PHYSICAL EXAMINATION

(MUST BE COMPLETED WITHIN 1 YEAR OF ADMISSION TO NURSING PROGRAM)

The Department of Nursing Education seeks to provide as much as possible a safe environment for nursing students and their clients. Students are required to demonstrate physical and emotional fitness to meet the core performance standards of the nursing program. Such essential requirements include freedom from communicable disease, the ability to perform certain physical tasks, and suitable emotional fitness.

1. PHYSICAL EXAMINATION DATE: _____
2. BASED UPON YOUR EXAMINATION OF THE ABOVE NAMED INDIVIDUAL, WERE YOU ABLE TO IDENTIFY PHYSICAL LIMITATIONS THAT WOULD PREVENT THIS INDIVIDUAL FROM PARTICIPATING AS A NURSING STUDENT AT SHEPHERD UNIVERSITY? YES NO

IF YES, PLEASE EXPLAIN _____

_____	_____		
PHYSICIAN or NURSE PRACTITIONER SIGNATURE	DATE		
_____	_____		
ADDRESS OF PRACTICE	CITY/STATE	ZIP	PHONE

FOR DEPARTMENT OF NURSING EDUCATION FACULTY USE ONLY