

Georgetown University School of Nursing & Health Studies

New Graduate Student Nurse Health Screening Form 2009 Academic Year

Office Use Only:

- This form must be returned to Sarah Crosley by July 1st for the Fall term or January 1st for the Spring term.
- A registration block and \$100 fee may result if all requirements are not met by the first day of class.
- Students must meet these requirements to participate in the clinical setting.

Return to:

Georgetown University
School of Nursing & Health Studies
Sarah Crosley
264 St. Mary's Hall
3700 Reservoir Road NW
Washington, DC 20057
Phone: (202) 687-8164
Fax: (202) 687-5553

E-mail: sfc28@georgetown.edu

Web: <http://nhs.georgetown.edu/students/NursingHealthClearances.html>

DEMOGRAPHIC INFORMATION | Completed by student. Please print.

Last Name	First	MI	Age	Date of Birth	Country of Birth		
GUID Number		Home Phone Number		City	State		
MSN Program (circle one):		ACNP	CCNS	ACNP/CCNS	FNP	NED	CNM
Date of Entry:		_____ Fall 2009	_____ Spring 2010	_____ Other _____			
Zip Code		City		State	Zip Code		

PHYSICAL | Completed by the health care provider.

I have examined this patient, _____, and he/she is in good health, adequate for participation in the clinical student nursing setting.

Signature: _____
Health Care Provider Date

IMMUNIZATIONS | Completed by health care provider.

1. Tetanus/Diphtheria/Pertussis (Tdap): ___/___/___ **OR**
Tetanus/Diphtheria Booster (Td): ___/___/___ if given within past 2 years

2. Varicella Blood Titer: ___/___/___ **OR**
Varicella Date of Dose 1: ___/___/___ AND
Varicella Date of Dose 2: ___/___/___

3. MMR Titer: ___/___/___ **OR**
MMR #1: ___/___/___ AND
MMR #2: ___/___/___

4. Hepatitis B: 1: ___/___/___ 2: ___/___/___ 3: ___/___/___ **OR**
Hepatitis B Titer: ___/___/___

Signature: _____
Health Care Provider Date

TB TEST | Completed by health care provider.

PPD Placed: _____
Mo/Day/Yr

PPD Read: _____ Negative / Positive
Mo/Day/Yr

OR

If PPD is positive, or student has previous history of a positive tuberculin skin test, a normal chest X-ray is required within 12 months, unless history of INH therapy is documented.
Date of INH treatment: _____.

X-ray date: _____ Negative / Positive
Mo/Day/Yr

Signature: _____
Health Care Provider Date