

Georgetown University School of Nursing & Health Studies

New Undergraduate Student Nurse Health Screening Form 2009 Academic Year

Return to:

Georgetown University
School of Nursing & Health Studies
Eliza Ycas
408D St. Mary's Hall; 3700 Reservoir Road NW
Washington, DC 20057
Phone: (202) 687-7258; Fax: (202) 687-2323
E-mail: ery@georgetown.edu
Website: <http://nhs.georgetown.edu/students/NursingHealthClearances.html>

- This form must be returned to Eliza Ycas by July 1 for the Fall term or December 15 for the Spring term.
- A registration block and \$100 fee may result if all requirements are not met by the due date.
- Students must meet these requirements to participate in the clinical setting.
- Note that in order for clearance you also need to complete a criminal background check and submit a copy of your current CPR certification to Eliza Ycas.

Parental permission or consent of legal guardian is needed to provide medical or surgical care to minors. The following statement should be signed by parents or guardians of students under 18 years of age to avoid delays in treatment in the event of an illness or accident:
I hereby authorize the staff of Georgetown University Student Health Center to interview, assess, test and if necessary treat my son or daughter as deemed advisable.

Signature: _____ Date: _____
Parent or Guardian

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	Zip Code
Date of Entry: _____ Fall 2009 _____ Spring 2010 _____ Other _____					
Program: _____ Traditional BSN _____ Accelerated Second Degree BSN					

PHYSICAL | Completed and signed 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: _____ Date: _____
Health Care Provider

IMMUNIZATIONS | Completed and signed 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: ___/___/___
5. **Meningococcus vaccine:** ___/___/___
Required of all freshman undergraduates living in residence halls. You may choose to waive this requirement. However, if you choose to waive you must read the Meningitis Fact Sheet, then sign **and submit** the Meningitis Vaccination Waiver. Both are found at <http://shc.georgetown.edu>.

Signature: _____ Date: _____
Health Care Provider

TB TEST | Completed and signed by health care provider.
2nd PPD should be placed 1-3 weeks after first PPD.

1. PPD Placed: _____
Mo/Day/Yr
PPD Read: _____ Negative / Positive
Mo/Day/Yr
2. 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: _____ Date: _____
Health Care Provider

INFLUENZA VACCINE | Completed and signed by the health care provider.

SEASONAL Vaccine Name: _____ Dosage (mL): _____ Date: _____ Signature: _____
Health Care Provider

H1N1 Vaccine Name: _____ Dosage (mL): _____ Date: _____ Signature: _____
Health Care Provider