

# Georgetown University School of Nursing & Health Studies

## Returning Undergraduate Student Nurse Health Screening Form 2009 Academic Year

Office Use Only:

### Return to:

Georgetown University  
School of Nursing & Health Studies  
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Website: <http://nhs.georgetown.edu/students/NursingHealthClearances.html>

- 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 an up-to-date criminal background check and current CPR certification.

### DEMOGRAPHIC INFORMATION | Completed by student. Please print.

Last Name	First	MI	Age	Date of Birth	Country of Birth
GUID Number	Phone Number	City	State	Zip Code	
Program:	_____ Traditional BSN	_____ Accelerated Second Degree BSN			

### TB TEST | Completed and signed 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

### PHYSICAL | Completed and signed by 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

### 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