Georgetown University School of Nursing & Health Studies

New CRNA Student Nurse Health Screening Form
2009 Academic Year

Office Use Only:

- **This form must be returned to Amanda Brandon 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
Amanda Brandon
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3700 Reservoir Road, NW
Washington, DC 20057
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Fax: (202) 687-2323
E-mail: amb257@georgetown.edu
Website: 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 Zip Code

Date of Entry: ______Fall 2009 ______Spring 2010 _______Other____________________________

DRUG SCREEN | Completed by health care provider.

The urine drug screen results for the patient ___________________________ are negative.
The urine drug screen tested for amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine metabolite, ethyl alcohol, methadone, opiates, phencyclidine, propoxyphene, and tricyclic antidepressants.

Signature: ____
Health Care Provider Date

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