Appendix B 1

LEWIS UNIVERSITY
COLLEGE OF NURSING AND HEALTH PROFESSIONS GRADUATE STUDIES

ONE UNIVERSITY PARKWAY
ROMEOVILLE, ILLINOIS 60446-2298
PHONE 815-836-5355

REPORT OF PHYSICAL EXAMINATION
PLEASE COMPLETE ALL ITEMS BELOW

IMPORTANT NOTE TO STUDENT: It is your responsibility to ensure that the required information is completed in ALL AREAS, and that all documentation is signed and dated as required. Incomplete documentation will be returned to the student.

____
Last Name (Print)   First Name   Middle   Maiden

____(______)________
Home Address (Number and Street)   City or Town   State   Zip Code   Home Phone

____
Emergency Contact   Home Telephone   Business Telephone

____
Emergency Contact   Home Telephone   Business Telephone

____
Citizenship   Date of Birth

PHYSICAL EXAMINATION
Are there any abnormalities
of the following systems?

Head Y N /Yr.
EN&T Y N/Yr.
Teeth Y N/Yr.
Respiratory Y N/Yr.
Cardiovascular Y N/Yr.
Gastrointestinal Y N/Yr.
Hernia Y N/Yr.

Genitourinary Y N/Yr.
Musculoskeletal Y N/Yr.
Metabolic/Endocrine Y N/Yr.
Neuropsychiatric Y N/Yr.
Skin Y N/Yr.
Is there loss or seriously impaired function of any organ?___Y N

HAVE YOU EVER HAD?

Measles Y N/Yr.
German Measles Y N/Yr.
Mumps Y N/Yr.
Chicken Pox Y N/Yr.

Blood Pressure__________ Height__________Inches_________ Weight_________ Lbs.

AT THIS TIME IS THIS PERSON ON ANY MEDICATION OR DOES THIS PERSON HAVE ANY CONDITION WHICH MAY ALTER OR IMPEDE PERFORMANCE IN NURSING PRACTICE? YES _______ NO________
Explain if yes:

____

____

Print Physician/Nurse Practitioner's Last Name ____

Physician/Nurse Practitioner's Signature:________________________________Date ________________

Address: ____

Physician/Nurse Practitioner's Phone Number :____

IMPORTANT: THIS FORM MUST BE COMPLETELY FILLED OUT, SIGNED, AND DATED BY PHYSICIAN/NURSE PRACTITIONER

Appendix B 2

Last Name (Print) ______ First Name ______ Middle ______ Maiden ______

REQUIRED DIAGNOSTIC TESTS: *IMPORTANT:* ALL AREAS MUST BE COMPLETELY FILLED OUT, WITH DATE AND RESULTS INDICATED.

DATE	TESTS	RESULTS
________	**2 - STEP TUBERCULIN SKIN TEST** (INITIALLY) (1-STEP REQUIRED ANNUALLY THEREAFTER)	(ALLOW 10-21 DAYS BETWEEN STEPS) NEG_______ POS_______ DATE____________ NEG_______ POS_______ DATE____________
________	CHEST X-RAY IS REQUIRED IF TB SKIN TEST IS POSITIVE	NEG_______ POS_______ DATE____________
________	**RUBELLA** (GERMAN MEASLES) TITER LEVEL OR PROOF OF IMMUNIZATION WITH LIVE VIRUS	NOT IMMUNE_____________ IMMUNE_____________ (attach copy of laboratory report)
________	**RUBEOLA** (MEASLES) TITER LEVEL (IF NOT IMMUNIZED WITH LIVE VIRUS 1980 OR AFTER)	NOT IMMUNE_____________ IMMUNE_____________ (attach copy of laboratory report)
_______	**MUMPS** TITER LEVEL (IF NOT IMMUNIZED)	NOT IMMUNE ____________IMMUNE _____________ (attach copy of laboratory report)
_______	**VARICELLA** TITER LEVEL (IF NO HISTORY, ATTACH REPORT)	**1.**______/______/______ **2.**______/______/______ (Vaccine dates)

REQUIRED IF NOT IMMUNE

Date/s of most recent immunization:

Rubella (German Measles) _________/_________/_________

Rubeola (Measles) **1.**______/______/______ **2.**______/______/______
(Illinois requires two immunizations)

Mumps _________/_________/_________

IMMUNIZATIONS **COMPLETED**

REQUIRED
Tetanus
Diphtheria

Dates (if known) of original series of DTP, DT and/or TD:
(MONTH, DAY, YEAR)

1.______/______/______ **2.**______/______/______ **3**.______/______/_____

Most Recent Booster:

_________/__________/__________ (Td Booster must have been within the past 10 years)

Physician/Nurse Practitioner's Signature____Date _____________

IMPORTANT: THIS PAGE MUST BE COMPLETELY FILLED OUT, SIGNED AND DATED BY PHYSICIAN/NURSE PRACTITIONER.

HEPATITIS FORM

Last Name (Print)	First Name	Middle	Maiden

REQUIRED

A. Hepatitis Vaccine (Series of 3 required)	______/______/______ Date — Physician signature/Health Care Provider ______/______/______ Date — Physician signature/Health Care Provider ______/______/______ Date — Physician signature/Health Care Provider

OR

B. Antibody Test Results Indicating Immunity	______/______/______ Date — Physician signature/Health Care Provider **NOT IMMUNE**_______________ **IMMUNE** (attach copy of lab report)

OR

C. Completion of Declination Form Below

HEPATITIS B VACCINATION DECLINATION

I understand that due to my nursing clinical practicum exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been encouraged to be vaccinated with hepatitis B vaccine. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B, a serious disease.

***Students are required to sign below unless the series of 3 immunizations has been completed.**

____ (Signature of Student)

_________________________________ (Date)

ANNUAL TB TESTING

The following documentation must be submitted to the Office of Graduate Studies annually.

TESTS	RESULTS
2-STEP TUBERCULIN SKIN TEST (INITIALLY)	NEG ______POS______DATE______
(ALLOW 10-21 DAYS BETWEEN STEPS)	
1-STEP REQUIRED ANNUALLY THEREAFTER	NEG ______POS______DATE______

IF TB SKIN TEST IS POITIVE – THE FOLLOWING TB SCREEN AKNOWLEDGEMENT IS REQUIRED

Tuberculin Screening Acknowledgement

Date:____

Name:____

Physician/Nurse Practitioner____

Those with a history of a positive TB skin test, should NOT BE RETESTED, but should answer and submit the following health history questions annually

Have you ever had a positive TB test?
No Yes
If yes when?____

Have you ever received the BCG vaccine?
No Yes

Have you ever had a skin conversion from negative to positive in the past two years?
No Yes

Have you ever had an abnormal chest x-ray?
No Yes
If yes when? ____

Have you ever been on steroids (cortisone) in the past 6 weeks?
No Yes

Have you recently had the mucous you cough up tested for TB?
No Yes

If yes were you told it was positive?
No Yes

Have you ever been told you have Infectious Tuberculosis?
No Yes

Have you ever been treated with medication for Infectious TB?.
No Yes

If yes, how many medications?
one two over two

Are you still taking medication?
No Yes

Did you take all the TB medicine until the physician told you that you were finished?
No Yes

Do you live with or have been in close contact with someone who was recently diagnosed with TB (e.g. roommate, close friend, relative)?
No Yes

I hereby acknowledge that I have submitted a negative x-ray. I will take full responsibility for reporting any of the early signs and symptoms of tuberculosis to a physician immediately.

Do I currently exhibit any of the following:

Fatigue (weakness).	No	Yes
Anorexia (loss of appetite)	No	Yes
Weight loss	No	Yes
Night sweats	No	Yes
Low grade fever	No	Yes
Productive cough lasting longer than 3 weeks	No	Yes
Hemoptysis (blood in sputum)	No	Yes

I have also have received information about the causes, treatment and prevention of tuberculosis, along with a reminder to report any of the above signs and symptoms to a physician. In the event that I need to contact a physician I will obtain a statement from him/her indicating it is appropriate for me to function in the health care field.

Student Signature____

Date ____

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LEWIS UNIVERSITY COLLEGE OF NURSING AND HEALTH PROFESSIONS

Health Insurance Verification

Please provide the following information:
Name of student ____
Name of insurance company____
Name of primary insured person____
Policy no. ____

The policy (check one)

- ❑ Is in effect from ________until __________ (Give dates).
- ❑ Provides continuous coverage as long as employee continues with employer.

If available:
Signature of insurance agent or personnel officer:_____________________________________
Phone: (___) ______-___________________

TO THE STUDENT

Your signature below verifies that you

Acknowledge that the above information is correct.

Understand that health insurance is required of all College of Nursing students enrolled in clinical nursing courses.

Agree to carry health insurance converge on a continued basis for the entire time enrolled in Lewis University College of Nursing clinical courses. If the policy has a termination date, you will provide ongoing documentation of continued coverage *before* the termination date.

Understand that failure to comply with this requirement can result in my being dropped from College of Nursing courses.

Further understand that the University is not responsible for your health insurance coverage or any cost incurred for health care treatment.

Student's Name (please print)____

Student's Signature____

Student's Social Security Number ____

Date: ____

Appendix B 6

ATTACH
A COPY OF YOUR
HEALTH INSURANCE CARD
(FRONT)

ATTACH
A COPY OF YOUR
HEALTH INSURANCE CARD
(BACK)

ATTACH
A COPY OF YOUR
CPR CARD
(FRONT)

ATTACH
A COPY OF YOUR
CPR CARD
(BACK)

ATTACH
A COPY OF YOUR
DRIVER'S LICENSE
(FRONT AND BACK, IF
RENEWAL STICKER ON BACK)

ATTACH
A COPY OF YOUR
AUTO INSURANCE
CARD

Appendix B 7

LEWIS UNIVERSITY
COLLEGE OF NURSING AND HEALTH PROFESSIONS
DEPARTMENT OF GRADUATE STUDIES
ONE UNIVERSITY PARKWAY
ROMEOVILLE, ILLINOIS 60446

CERTIFICATE OF PARTICIPATION IN OSHA Bloodborne Pathogens Program

This is to certify that ________________________________has attended an OSHA Bloodborne Pathogens update at his/her agency on the date indicated below. The OSHA Bloodborne Pathogens update covered the following topics at a minimum:

1. Accessible copy of the regulatory text and explanation.

2. General explanation of bloodborne pathogens' epidemiology and symptoms.

3. Explanation of mode of transmission of bloodborne pathogens.

4. Explanation that Exposure Control Plans are specific to agencies and will be provided at the time of the first experience within each agency.

5. Method for recognizing tasks that may involve exposure to blood and other potentially infectious materials.

6. Methods to reduce exposure, i.e., appropriate engineering controls, work practices, and personal protective equipment (PPE) including location, proper use, disposal, etc.

7. Infection on hepatitis B vaccine, i.e., availability, safety, efficacy, etc.

8. General information regarding exposure follow-up procedure and explanation, with specific agency-connected information as presented in number four above.

9. Opportunity for interactive questions and answers.

___________________________________	___________________________
Authorized Agency Representative Signature	**Title**
___________________________________	___________________________
Program Date	**Agency**
___________________________________	___________________________
Agency Street address	**Agency City, State, Zip Code**

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CERTIFICATE OF PARTICIPATION IN
Prevention of Transmission of Tuberculosis in Healthcare Facilities

This is to certify that ___________________________________has attended an OSHA Prevention of Transmission of Tuberculosis in Healthcare Facilities update at his/her agency on the date indicated below. The OSHA Prevention of Transmission of Tuberculosis in Healthcare Facilities update covered the following topics at a minimum:

1. General explanation of the basic concepts of TB transmission including the difference between latent TB infection and active TB disease.
2. Explanation of the signs and symptoms of TB.
3. Discussion of the potential for occupational exposure.
4. Discussion of the need for isolation of patients with TB or suspect TB.
5. Practices to reduce the risk of transmission of TB.
6. Explanation of the purpose of PPD skin testing.
7. Discussion of the principles of preventive therapy.
8. Responsibility of the health care worker to seek medical evaluation promptly if symptoms of TB develop or PPD conversion occurs.
9. Principles of drug therapy for active TB disease.
10. Responsibility for maintaining the confidentiality of the health care worker.
11. Discussion of the immunocompromised health care worker and TB.
12. Opportunity for interactive questions and answers.

_____________________________________ _____________________________
Authorized Agency Representative Signature **Title**

_____________________________________ _____________________________
Program Date **Agency**

_____________________________________ _____________________________
Agency Street address **Agency City, State, Zip Code**

Appendix B 9

LEWIS UNIVERSITY
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DEPARTMENT OF GRADUATE STUDIES
ONE UNIVERSITY PARKWAY
ROMEOVILLE, ILLINOIS 60446

CERTIFICATION OF PARTICIPATION IN HIPAA PROGRAM

This is to certify that _________________________has attended an annual HIPAA staff development update at his/her agency on the date indicated below. The annual HIPPA update covered the following topics at a minimum:

1. General explanation of the HIPAA (Healthcare Insurance Portability and Accountability Act) privacy rule.

2. Explanation of four entities covered by this Act.

3. Explanation of health information covered by Act: PHI (Protected Health Information), IIHI (Individually Identifiable Health Information).

4. Explanation of appropriate uses of PHI: disclosure, MNI (Minimum Necessary Information).

5. Identification of patient rights under HIPAA: NPP (Notice of Privacy Practices)/consent form, patient rights summary, authorization form.

6. Identification of elements needed for authorization and allowed exceptions to authorization.

7. Explanation of relationship between HIPA and state laws.

8. Explanation of general day-to-day use of HIPAA.

9. Opportunity for interactive questions and answers.

______________________________	______________________________
Authorized Agency Representative Signature	**Title**
______________________________	______________________________
Program Date	**Agency**
______________________________	______________________________
Agency Street address	**Agency City, State, Zip Code**

OCCUPATIONAL HAZARD/TB EXPOSURE OCCURRENCE REPORT

Directions: Complete this form if you are exposed to an occupational hazard or TB during a scheduled experience required in meeting course objectives in the nursing curriculum. The faculty directing the experience must sign this form to indicate awareness. Submit the completed form within 24 hours of occurence to the Office of Graduate Studies in the College of Nursing and Health Professions This form may be faxed to

(815)838-8306

Attention: Director of Graduate Studies

Date and time of occurrence____

Location____

Type and source of hazard (exposure to infectious material, accident, equipment malfunction, etc.)

Type________________________________Source____________________________

Type of occurrence ____

Personal protective equipment in use (If Applicable)

Actions taken post occurrence

Recommendations for avoiding future occurrences

Student Signature_____________________________Date________________________

Faculty Signature_____________________________Date________________________

Please note:

The next two pages are to be submitted directly to the Lewis University Health Center per Illinois State Law.

This is ***distinct*** from the health and clinical requirements of the CONHP. It is the ***student's responsibility*** to be certain this immunization documentation requirement is met by submitting this form to the Lewis University Health Center. Please complete and mail to:

Center for Health and Counseling Services
Box 273
Lewis University
One University Parkway
Romeoville, IL 60446-2200

This requirement is NOT met by submission of CONHP health and clinical information and does NOT meet the CONHP health and clinical requirements.

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ILLINOIS STUDENT IMMUNIZATION REQUIREMENT

INSTRUCTIONS:

- In accordance with state legislation and actions of the Illinois Department of Public Health, Lewis University requires that this form be completed and returned one month prior to the first day of the semester in which a student is first enrolled. This requirement applies to all newly admitted students, Including new graduate students, readmitted students, and transfer students.

  This law pertains to you if you:

  - Were born after January 1,1957 (if born before 1957, see #4 below)
  - Take 6 or more credits a semester on the Romeoville Campus (including graduate, readmitted or transfer students).

- If you meet the above criteria, you must present Lewis University with copies of Immunization records showing you have received the following immunizations:

  1. Measles, mumps and rubella vaccine (MMR) received after 1 year of age.
  2. A Second measles vaccine received after 1 year of age.
  3. Tetanus diphtheria (Td) vaccine within the last 10 years.
  4. Note: If born before 1957, you are considered immune to measles, mumps, and rubella, but one dose of Td must have been given within the last 10 years.

- Students must show proof of immunizations. Have a health care provider complete this form or seek immunization records from your personal physician or the medical record from your former high school/university, or military records.

- If completed by Physician/Health Care Provider a signature verifying information is required.

- ALL DATES MUST INCLUDE MONTH/DAY/YEAR.

- Exemptions:
  Medical exemptions must include physician's letter of explanation and date exemption ends.
  Individuals requiring religious exemptions must contact the Health Services Nurse.

- KEEP A COPY of this form in your personal health records or in the event it is not received by The Center for Health & Counseling Services.

- MAIL COMPLETED IMMUNIZATION INFORMATION FORM AND HEALTH HISTORY FORM TO:

Lewis University
The Center for Health and Counseling Services
One University Parkway, Box #273
Romeoville, Illinois 60446
FAX (815) 836-5047

- For additional immunization information, call the Center at (815) 836-5455.

NOTE: Fines will be assessed to alt students who do not come into compliance before the tenth week into the student's first semester. Students must pay all fines. These fines will escalate each semester of continued non-compliance. In addition, grades may be withheld and the Illinois Department of Public Health can demand refusal of class registration for the following semester.

Continue to next page

YOUR SIGNATURE IS REQUESTED HERE

PRIVACY RIGHTS WAIVER

I give my consent to allow this form to be viewed by officials of the Illinois Department of Public Health as part of their compliance audit of the university and in the event of a health or safety emergency.

Signature ____

Date ____