PART ONE: Physical Exam TO BE COMPLETED IN INK BY HEALTH CARE PRACTITIONER

I have examined _____ on
(student name)

_____ and have found him/her to be free of communicable disease and physically able to
mm/dd/yy

perform his/her assigned duties in the RN First Assistant Registered Nurse First Assistant courses at the

University of Rochester School of Nursing, Center for Lifelong Learning.

_____ _____
Physician's Signature Date

(Physical Examination must be completed within the past year)

PART TWO: THE REQUIREMENTS BELOW NEED HEALTH CARE PROVIDER VERIFICATIONS

FEDERAL, NEW YORK STATE & UNIVERSITY HEALTH REQUIREMENTS:

Measles (rubeola): Two (2) doses of live vaccine. The vaccine must have been given on or after the first birthday, in 1968 or later, and without immune globulin. A second dose of measles vaccine must meet the same requirement, but should be given no sooner than 30 days after the first dose. Serologic evidence of measles immunity is acceptable for establishing immunity.

Mumps vaccine: Two (2) doses of live vaccine given on or after the first birthday AND on or after 1/1/69. Serologic evidence of mumps immunity is acceptable for establishing immunity.

Rubella: One (1) dose of live vaccine given on or after the first birthday AND on or after 1/1/69. Serologic evidence of immunity is acceptable.

Meningococcus: One (1) dose of vaccine within the last 10 years, or written acknowledgement of receipt of information concerning vaccination and signature declining vaccination.

Tuberculin Skin Test: Two TST (Mantoux intradermal skin test) and interpretations are required, the first within one year of the second and the second within 3 months of the start of appointment, unless history of past positive skin test is reported. Chest x-ray: If the TST is positive, a negative chest x-ray report after a positive TST is required. BCG vaccination alone does not meet the requirement.

Tetanus-Diphtheria: Tetanus – Diphtheria (initial series) and booster every 10 years. OR Tdap The CDC recommends that health providers who have direct patient contact should receive a single dose of Tdap as soon as feasible if they have not previously received it.

Polio: All students must have received polio vaccine. Enter the date of last vaccination on the form. Either Oral (OPV) or Intramuscular (IPV) forms of vaccine are acceptable.

Hepatitis B vaccine: The CDC strongly recommends hepatitis B vaccination for health care professionals. A post vaccine titer is necessary to assure immunity. A signed declination form must be completed if you decline vaccine.

Varicella History: If no documented disease history, serological test is required. If negative, vaccination with 2 Varicella vaccines is strongly recommended. A signed declination form must be completed if the applicant declines vaccine.

Instructions  MMR  Documentation	**MEASLES (Rubeola)** * **2 Doses of live vaccine** given <u>on or after the first birthday</u>: must be given at least 28 days apart with the second dose after age 15 months *OR **serologic test** showing positive titer (lab report must be included) ****May substitute MMR.***	**MUMPS** * **2 Doses of live vaccine** given <u>on or after the first birthday</u>: must be given at least 28 days apart with the second dose after age 15 months *OR **serologic test** showing positive titer (lab report must be included) ****May substitute MMR.***	**RUBELLA** * **1 dose of live vaccine** given <u>on or after the first birthday</u> * OR **serologic test** showing positive titer (lab report must be included) * ***May substitute MMR.***
MMR Documentation **1st Immunization:_____** **mm/dd/yy** **AND** **2nd Immunization: _____** **mm/dd/yy**	**Measles Documentation** **1st Immunization:_____** **mm/dd/yy** **AND** **2nd Immunization:_____** **mm/dd/yy** **OR** **Serologic Test:_____** **mm/dd/yy** **Result:** ☐ Positive ☐ Indeterminate ☐ Negative	**Mumps Documentation** **1st Immunization:_____** **mm/dd/yy** **AND** **2nd Immunization:_____** **mm/dd/yy** **OR** **Serologic Test:_____** **mm/dd/yy** **Result:** ☐ Positive ☐ Indeterminate ☐ Negative	**Rubella Documentation** **1st Immunization:_____** **mm/dd/yy** **OR** **Serologic Test:_____** **mm/dd/yy** **Result:** ☐ Positive ☐ Indeterminate ☐ Negative

TUBERCULIN SKIN TEST (MANTOUX) REQUIRMENTS

Two TST's (Mantoux intradermal skin tests) – The **1st** is due within one year of the start date of the program and the **2nd** is due within 3 months of that start date. Tine tests or history of BCG do not meet the requirement. If positive TST or history of past positive TST is reported, a chest x-ray must be obtained after positive TST and a copy of the chest x-ray report attached. *Example:* Start Date (9/1/12)

1st TST (9/1/11 to 8/1/12)
2nd TST (6/1/12 to 8/31/12)

TST#1	TST#2	Past Positive	Chest X-Ray
Manufacturer: _____ **#1 Date Placed:_____** **mm/dd/yy** **Date Read:_____** **mm/dd/yy** **mm of induration:_____** **mm/dd/yy** **Interpretation:** ☐ Positive ☐ Negative	**Manufacturer: _____** **#2 Date Placed:_____** **mm/dd/yy** **Date Read:_____** **mm/dd/yy** **mm of induration:_____** **mm/dd/yy** **Interpretation:** ☐ Positive ☐ Negative	**Date:_____** **mm of induration:_____**	**Obtained** after positive TST **Date:_____** **Result:_____** **A copy of official radiology report MUST be attached** **DO NOT SEND X-RAY**

TETANUS-DIPHTHERIA OR Tdap

Immunization:_____ ☐ **Td** ☐**Tdap**
mm/dd/yy

TETANUS-DIPHTHERIA (every 10 years)
OR
Tdap: The CDC recommends that health providers who have direct contact should receive a single dose of Tdap as soon as feasible if they have not previously received it. Reference: 12/06
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5517a2.htm

Polio Vaccine

☐ **IPV** ☐**OPV**

Immunization:_____ (date of completion)
mm/dd/yy

IMMUNIZATIONS AND TESTS: INFORMATION IS REQUIRED

Hepatitis B vaccine: The CDC **STRONGLY RECOMMENDS** hepatitis B vaccination (includes 3 doses of vaccine and **post-vaccine titer 1-2months after 3rd dose)** for all health care professionals. A signed declination form **must be completed** if the applicant declines vaccine.

Varicella History: If no confirmed disease history, vaccination with 2 doses of varicella vaccine is strongly recommended. A positive titer result may also be presented as proof immunity to varicella. A signed declination from **must be completed** if the applicant declines vaccine.

Meningococcus Vaccine: Review enclosed information

HEPATITIS B

Immunization #1**:**_____
mm/dd/yy

Immunization #2**:**_____
mm/dd/yy

Immunization #3**:**_____
mm/dd/yy

Serologic Test:_____ **Results:** _____
mm/dd/yy (lab report must be included)

Only submit serologic test results if done 1-2 months after 3rd dose of vaccine administered

☐ **DECLINATION:** I **decline** the hepatitis B Vaccination at this time. I understand that by declining this vaccine, I continue to be at risk for acquiring hepatitis B. I understand the risks of being susceptible to infections and blood borne diseases and decline immunization at this time. I understand I may choose to receive the vaccine at any time in the future.

Declination Signature of Student:

_____**Date**_____

VARICELLA (CHICKEN POX)

Disease history _____
mm/yy

OR (if no disease history)

Serologic Test:_____ **Results:** _____
mm/dd/yy (lab report must be included)

☐ **DECLINATION:** I **decline** the hepatitis B Vaccination at this time. I understand that by declining this vaccine, I continue to be at risk for acquiring hepatitis B. I understand the risks of being susceptible to infections and blood borne diseases and decline immunization at this time. I understand I may choose to receive the vaccine at any time in the future.

Declination Signature of Student:

_____**Date**_____

MENINGOCOCCUS VACCINE: _____
mm/dd/yy

☐ **DECLINATION:** I **certify** that I have received the information about the risks, benefits, availability and alternatives to meningococcus vaccination. I understand the information and I decline the meningococcus vaccination at this time. I understand that by declining this vaccine, I continue to risk acquiring meningitis. I understand I may choose to receive the vaccine at any time in the future.

Declination Signature of Student:

_____**Date**_____

Optional
HUMAN PAPILLOMA VIRUS VACCINE (HPV):

Immunization #1**:**_____
mm/dd/yy

Immunization #2**:**_____
mm/dd/yy

Immunization #3**:**_____
mm/dd/yy

PART THREE: TO BE COMPLETED IN INK BY HEALTH CARE PRACTITIONER

I have reviewed all the above information including immunization dates and physical exam form and it is correct to the best of my knowledge.

Practitioner's Name (please print) :_____

Practitioner's Signature:_____

Address:_____
City **State** **Zip Code** **Country**

Work Telephone ( )_____ **Date of completion of form** _____/_____/_____