



THE CATHOLIC UNIVERSITY OF AMERICA
School of Nursing
620 Michigan Avenue, NE
Washington, DC 20064

Dear Health Care Provider:

Your patient is a CUA nursing student. In order for a student to practice in clinical settings as part of their nursing education, we require (a) an annual review of immunizations and a PPD (b) identification of any health related conditions that may impact the ability to work in the clinical setting since students may be placed in medical, surgical, pediatric, obstetric, and psychiatric settings. Health clearance and information about their health status is essential.

Enclosed, please find The Catholic University of America School of Nursing *Health Forms*, which must be completed by their provider before the student can be placed in a clinical setting. After completing this form, please have the student sign the attached certification statement and mail the original copy of the completed form in an envelope marked **CONFIDENTIAL** to:

The Catholic University of America
School of Nursing
Office of the Dean
620 Michigan Avenue NE
Washington, DC 20064
ATTN: Stephanie Adams

If you have any questions, please contact the School of Nursing 202-319-5400.

Sincerely,

Nalini Jairath, PhD, RN
Dean, School of Nursing

Revised 06/28/06 SAA

Located on shared drive under UG Admin file then health Info document name UG; Grad Health Form



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Name of Student: _____

Date: _____

Health History			
1. Does the student have any of the following conditions which could interfere with their ability to practice in a clinical setting?	Yes*	No	
• Medical Condition	Yes*		
• Mental Condition	Yes*		
• Chemical Dependency Condition	Yes*		
• Pregnancy	Yes*		
• Other (Please explain)	Yes*		
*If you answered Yes to any of the above, please explain:			
Immunization History		Date	
Polio: Date original series completed			
DPT: Date original series completed			
Tetanus: Last booster (Must be within 10 years)			
Measles: (Since 1980) or immune titer (Must attach lab results)			
Mumps:			
Rubella: Date of vaccine or immune titer (Must attach lab results)			
Varicella (Chicken Pox): Date of Vaccine or immune titer (Must attach lab results) If history of disease, <u>must</u> have immune titer			
Hepatitis B:	1 st	2 nd	3 rd
Tuberculin Test (PPD or chest x-ray): *If positive, a chest x-ray (within one year) must be done. Date of chest x-ray: _____ Results: _____			
If the student has ever had a positive PPD or chest x-ray, please complete the attached Tuberculin Symptom & Health Survey.		Negative	Positive*



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CERTIFICATION STATEMENTS

Certification by Health Care Provider

I, _____ hereby certify that I have completed a physical of
(name of physician or certified nurse practitioner)

_____ and that in my medical opinion there are:
(name of student/patient)

_____ no current conditions which would disqualify the student from participating in
the nursing clinical rotations at the present time

_____ limitations which include: _____

Please check one of the following:

- _____ I can recommend
_____ I cannot recommend

Signature: _____ Date: _____

Address: _____ Telephone Number: (_____) _____

Certification by Student

I have read the above and hereby certify that it is complete and accurate and that I have fully disclosed any conditions that might interfere with the Safe Nursing Practice requirements at CUA School of Nursing.

Printed Name: _____ Signature: _____

Date: _____



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**Questionnaire for Nursing Students
Who Have Tested Positive to PPD Skin Test**

According to our records you are positive to PPD skin testing. Therefore, we are requesting that you complete the following questionnaire and return it to Undergraduate Nursing Office.

Please mark **Y** (yes) or **N** (no) if you experienced any of the following over the past year:

- Chronic Cough (over 3 weeks)
- Weight Loss (unexplained)
- Fever/Chills/Night Sweats
- Bloody Sputum
- Recent Exposure to Active TB
- Past Diagnosis

If you have checked two or more of the above, you may be contacted for further explanation or clarification and possible referral for chest x-ray.

If at any time during the year you experience any of the above symptoms, please contact the Associate Dean of the Undergraduate Nursing Program.

Date: _____

Student Name: _____

Student Signature: _____

Primary Care Provider Name: _____

Primary Care Provider Signature: _____

