Student Health- Immunization Requirements

Failure to meet initial and ongoing Health-Immunization requirements will prevent students from entering a clinical practicum until such time as student submits requirements, and may jeopardize student’s academic progress/and or standing.

___ TB Skin Test
An initial 2 step TST (2 TST’s done at least one week apart) is required within 3 months of entering the program. A Quantiferon (QFT) Gold Blood test is acceptable in lieu of the 2 step test. Each year after completing the 2 step TST an annual 1 step TST renewal is required or a QFT.

___ TB Converters (applies only if TST or QFT is Positive)
If the results of the TB skin test or Quantiferon Gold Blood test are positive, a clear chest x-ray is required within 3 months of entering the program and completion of the TB Symptom Review Form. Thereafter, the TB Converters TB Symptom Review Form needs to be updated annually.

NOTE: While the University requires proof of immunizations, the College of Health and Human Services, School of Nursing requires titers/screens for the following:

___ Measles, Mumps, Rubella (MMR) Titers
Documentation of a positive antibody titer for each component in a lab report within the past 10 years must be submitted as proof of immunity.

___ Hepatitis B Immunity
Documentation of a positive antibody titer in a lab report within the past 10 years must be submitted as proof of immunity.

___ Varicella Titer
Documentation of a positive antibody titer in a lab report within the past 10 years must be submitted as proof of immunity.

___ Tetanus, Diphtheria & Pertussis
Documentation of a Tdap booster within the past 10 years OR positive antibody titers for each component in a lab report must be submitted as proof of immunity.

___ Influenza Vaccination or Declination Form
There must be documentation of either an annual flu shot OR the signed declination form.
**BLS Certification American Heart Association ONLY**
The course must be Healthcare Provider conducted by the American Heart Association. A copy of the front and back of the card is required and it must be signed. Certification must be renewed every 2 years.

**Proof of Health Insurance**
Must submit proof of health insurance coverage. A copy of the front and back of the card is required.

**CA RN License (as applicable)**
Must submit a copy of your CA RN License or documentation that verifies you hold a license. The documentation must include your name, license number, expiration date, and status.

**Entrance Physical Exam**
Use the form provided by the University, it must be completed and signed by a medical professional.

**Emergency Contact Form**
Use the form provided by the University, fill it out completely.

NOTE: Some clinical sites may require additional testing e.g. Drug screening, Fingerprinting, T spot blood assays, and fees may be required. All health requirements are determined by each clinical site and are subject to change at any time with limited notice.

**INFORMATION ABOUT TITERS**
If a titer result is negative or equivocal, you will be required to receive another immunization and re-draw the titer one month after the immunization. If the titer is again equivocal or negative no further testing is needed.

**I NEED HELP!!!**
If you need assistance with your immunization tracker please visit the help section located in the upper right corner of the website. Here you will find tutorials that you can watch that will show you how to create your Magnus account all the way through completing each requirement. If you need further assistance please contact CertifiedBackground.com at 888-666-7788 or customerservice@certifiedbackground.com and a Student Support Representative will be available from 8am to 6pm EST.

REMINDER: Start Early!! Check with the SFSU Clinical Coordinator if you have questions. Keep up to date with your health records online and maintain your own personal file. It is your responsibility to ensure you are CLEAR for clinical rotations.

Contact at San Francisco State University School of Nursing is:
Shirl Kedrowski, MSN, RN via email: shirl@sfsu.edu
SFSU Clinical & Contracts Coordinator
ENTRANCE PHYSICAL EXAMINATION REPORT

An entrance physical examination is required for every student in the nursing program as a means of ascertaining the student’s health status. This must be completed before the student enters the nursing program.

The physician or nurse practitioner is requested to review and validate the student's health history. The physical examination is expected to support the statement signed below and include, at least, an assessment of heart, lungs, back, eyes, and ears.

Student’s Name: __________________________________________ (typed or printed)

Date of Examination: _______________________________________

The above named student is enrolled in the nursing program and will be caring for client in homes, hospitals, offices and other institutions.

I have reviewed the patient’s history and have performed a physical examination and find that this student: (check one)

_____ is in good health and has no condition (physical, mental, emotional) which limits his/her functioning in the nursing program.

_____ is unable to perform the required duties safely in the nursing program.

Explanation: ________________________________________________

Signature of Examiner: _______________________________________

Examiner’s Name: ____________________________________________ (typed or printed)

California License Number: ________________________________

Examiner’s Address: _________________________________________

Examiner’s Telephone: _______________________________________

EMERGENCY CONTACT FORM

<table>
<thead>
<tr>
<th>Date:</th>
<th>ID Number:</th>
<th>Date Entered Program:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name:</td>
<td>First:</td>
<td>Middle:</td>
</tr>
<tr>
<td>Address:</td>
<td>City:</td>
<td>Zip Code:</td>
</tr>
<tr>
<td>Tel. Home:</td>
<td>Cell:</td>
<td>Work:</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>E-Mail:</td>
<td>Your Advisor:</td>
</tr>
</tbody>
</table>

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>City:</td>
</tr>
<tr>
<td>Tel. Home:</td>
<td>Work:</td>
</tr>
</tbody>
</table>

OPTIONAL

The following information will allow the School of Nursing to gather data regarding the students we serve in terms of gender, veteran status, disability, and ethnicity. Check correct responses/answer questions:

- Male _____ Female _____ Veteran ______
- American Indian/Alaskan Native _____ 2) Asian ______ 3) Black or African-American _____
- Hispanic/Latino ______ 5) Native Hawaiian/Other Pacific Islander _____ 6) White ______

Number of dependents: ______

Do you have healthcare related work experience? _____ Yes _____ No

Number of hours of work per week: ________ Number of hours volunteering per week: ________

Commute distance to school in miles (one way): ________

School status: _____ Full time (6.1 units or more) _____ Part time (up to 6.0 units)

Using the definition below, I qualify as a low-income student based on my family size and current income: _____ Yes _____ No

<table>
<thead>
<tr>
<th>Size of Family *</th>
<th>Income Level **</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Includes only dependents listed on federal income tax forms.</td>
<td>** Adjusted gross income for previous calendar year rounded off to $100.</td>
</tr>
<tr>
<td>1</td>
<td>$17,960</td>
</tr>
<tr>
<td>2</td>
<td>$24,240</td>
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<td>3</td>
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<tr>
<td>4</td>
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<td>5</td>
<td>$43,080</td>
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<tr>
<td>6</td>
<td>$49,360</td>
</tr>
</tbody>
</table>

June, 2011
Annual Tuberculosis Symptom Review

This form must be completed by students with a history of positive TB skin test. The information requested below is designed to protect the health of our students and the patients they serve. All responses will remain confidential. If your answers suggest that further evaluation is needed, you will be asked to see a provider for appropriate medical follow-up.

Name ___________________________ Date of Birth ________ SFSU ID Number ________
Program /Level __________________ Email Address __________________ Cell Phone ________ Home Phone ________

**TB History**
Date of Positive Skin test: ___________ Size in millimeters ______
Date of Last Negative Skin Test: ___________
Did you take INH? ❑Yes (Please indicate dates) ___________
❑No (Please schedule an appointment with the Clinical Placement Coordinator.)

1. Were you born in the United States? ❑Yes ❑No
   If no, where were you born? ________________
2. Have you ever received BCG (TB vaccine)? ❑Yes ❑No
   If yes, when? ________________
3. Have you had a chest x-ray in the past? ❑Yes ❑No
   If yes, when? ________________

**In the PAST 12 MONTHS:**
4. Have any of your family or friends been diagnosed with active tuberculosis? ❑Yes ❑No
5. Have you entered a TB isolation room? ❑Yes ❑No
6. Have you had an exposure to a known case of TB? ❑Yes ❑No
7. Have you traveled or lived outside the United States? ❑Yes ❑No
   If yes, where? ________________
8. Have you had a cough that lasted longer than 3 weeks? ❑Yes ❑No
9. Have you coughed up any blood? ❑Yes ❑No
10. Have you experienced night sweats? ❑Yes ❑No
11. Are losing weight without trying to do so? ❑Yes ❑No
12. Has there been a significant decrease in your level of energy (not due to school or work load)? ❑Yes ❑No

**Note:** SFSU School of Nursing will review and approve.

By signing this form, you declare and certify that the answers provided are true and correct.

______________________________  __________________
Student Signature                   Date
Declination of H1N1/Influenza Vaccination

The SFSU School of Nursing has recommended that I receive the H1N1/influenza vaccination in order to protect the patients I serve. I am declining the H1N1/influenza vaccine due to:

_____ Medical contraindication (allergy to eggs and/or thimerosal, history of Guillain-Barré Syndrome, or anaphylactic reaction to a previous flu vaccine)

_____ I am aware of the following facts but am choosing to decline the vaccine (indicate why you are declining below):

• Influenza is a serious respiratory disease that kills an average of 36,000 persons and hospitalizes more than 200,000 persons in the United States each year.
• Influenza vaccination is recommended for me and all other healthcare workers to prevent influenza disease and its complications, including death.
• If I contract influenza, I will shed the virus for 24–48 hours before influenza symptoms appear. My shedding the virus can spread influenza infection to patients in this facility.
• If I become infected with influenza, even when my symptoms are mild, I can spread severe illness to others.
• I understand that the strains of virus that cause influenza infection change almost every year, which is why a different influenza vaccine is recommended each year.
• I cannot get the influenza disease from the influenza vaccine.
• The consequences of my refusing to be vaccinated could endanger my health and the health of those with whom I have contact, including: 1) Patients in the healthcare setting 2) My coworkers 3) My family 4) My community

Please indicate why you are declining the vaccine (i.e. afraid of needles, don’t believe in vaccines, fear the vaccine may make you ill, etc.

________________________________________________________________________

I have read and fully understand the information on this declination form.

Student Signature: ____________________________________________ Date: ___________________

Name (print): ________________________________________________________________