Health Assessment and Immunization

The Department of Nursing Health Assessment and Immunization Form is located in Appendix L. Specific Immunization Requirements include the following:

1. **Tetanus Immunization**: Generally a basic series of Diphtheria/Pertussis/Tetanus (DPT) is given during childhood with tetanus boosters. Beyond age 7, Pertussis is not considered essential. A tetanus booster is required every 10 years.

2. **Measles, Mumps, Rubella (MMR)**
   a. Measles (Rubeola): The initial series is given during childhood. However, if student was born after 1957 and immunized prior to 1980, the student must be revaccinated or show a positive titer (if the titer is negative, must be revaccinated). If the student was born before 1957, she/he must have a history of Rubeola or show a positive titer. If the titer is negative, she/he must be vaccinated. If the individual was immunized after 1980, the initial immunization is given during childhood, with a booster during the grade Department years. Documentation of immunization is sufficient.
   b. Mumps: Immunization is needed if the individual has no documentation of illness.
   c. Rubella (German measles): The initial series is given during childhood. However, if student was born after 1957 and immunized prior to 1980, the student must be revaccinated or show a positive titer (if the titer is negative, must be revaccinated). If the student was born before 1957, she/he must have a history of rubella or show a positive titer. If the titer is negative, she/he must be vaccinated. Students immunized after 1980 must have verification of immunization. NOTE: In most cases, for a typical adult, 2 injections of MMR are required.

3. **Polio**: A completed primary series of polio immunization (3 doses) is required.
   a. Oral Polio Vaccine (OPV) usually will not be given on or before age 18.
   b. Inactivated Polio Vaccine (IPV) can be given on or after age 18 if no immunization received as a child.
   c. If less than a full primary series was given, the series must be completed as medically directed.

4. **Hepatitis B**: This immunization is given in three doses. The second dose is given 4 weeks after the first dose and the third dose is given 5-6 months after the first dose.

5. **Varicella** (Chicken Pox): Student must obtain serologic screening documented on the student health record. If the titer is negative, she/he must be vaccinated. The series is two immunizations, 4-8 weeks apart.

6. **Tuberculosis** (TB): Students must have documentation of PPD every 12 months and record same at the Nursing office. Use the 5 tuberculin unit (TU) preparation applied by the Mantoux (intradermal technique). This test must be read 48-72 hours after injection.
   a. Current Cutoffs:
      > = 5 mm: Household contact of TB case, persons with clinical suspicion of TB, or persons with HIV infection.
> = 10 mm: Persons with risk factors for TB but not in above group - foreign born persons from high prevalence countries, medically underserved low income, high risk ethnic minorities, IV drug users, residents of long-term care facilities, health care workers, and persons with medical conditions associated with higher risk of TB.

>= 15mm: Remainder of population. This cutoff was chosen because positive reactions have near 100% specifically, thus minimizing false positives in low-risk populations.

Prior BCG Vaccination can be one cause of a false positive PPD. However, since BCG does not guarantee protection from tuberculosis and TB is very prevalent in many countries where BCG is given, one should IGNORE BCG STATUS when interpreting the PPD.

b. Screening and Prevention of TB:

“REACTOR” Person who meets criteria for positive test given cutoffs above.

CONVERTER = Person younger than 35 years of age whose PPD has changed from negative to positive during sequential testing, with an increase of at least 10 mm within 2 years. For those over 35 years age, an increase of 15 mm or more within a 2-year period is considered a conversion.

Students with positive PPD tests need to obtain a chest x-ray and medical follow-up. If abnormalities are seen, active disease must be ruled out with sputum cultures. Active disease can be ruled out by a Negative chest x-ray and/or sputum culture; a complete a symptomatic review is required every 12 months with signature from your medical practitioner. The student may return to clinical practice once the Department of Nursing sends a letter from the healthcare provider on their letterhead and signed by the provider that indicates the appropriate intervention has been achieved and the student has no evidence of active disease.

7. Influenza: Students will be providing direct care to vulnerable populations and will be considered under the classification of “healthcare provider” related to the Center for Disease Control (CDC) recommendations for immunization for influenza. This is a seasonal vaccine usually available in the fall of the year. Please be advised that some clinical agencies may require evidence of immunization for seasonal influenza and H1N1 (swine flu) prior to clinical placement. This could require two separate vaccines. If this is the case, the Director of Nursing will notify students in writing prior to implementation of this requirement. The student will be responsible for the cost of this requirement. Additional information on the current influenza situation, please go to either the Ohio Department of Health or CDC web sites.

Note: These immunization requirements are based on the Ohio Department of Health recommendations for nursing students and on information from the CDC. These guidelines provide protection from preventable or communicable disease for students, their patients, and families.

CAUTION: Students who are pregnant, have an impaired immune system or are caring for an immunosuppressed person, or have allergies should notify the Wellness Clinic or physician prior to receiving immunizations. A waiver can be signed based on medical recommendations. The completed waiver is to be submitted to the Department of Nursing secretary and the clinical faculty need to be informed by the student. Clinical agencies retain the right to decline student placement if
there is risk associated with lack of immunity evidence. This is for the protection of the student and/or the patient.
Appendix L. Department of Nursing Health Assessment

The information provided to the Department of Nursing in the following health assessment tool will be housed in the Department of Nursing according to the record retention schedule.

Name: _________________________________ Social Security #: ______________________
Age: _______ DOB: _______ Sex: ___________ Student ID# _______________________
Current Health Conditions: _______________________________________________________
Chronic Health Problems: _______________________________________________________
Current Medications: ___________________________________________________________
Hospitalizations: ________________ ______________________________________________
Surgeries: ___________________________________________________________________
Childhood Diseases: ___________________________________________________________
Last Dental Exam: ___________________________ Last Eye Exam: _____________________
FEMALES: Last Pelvic and Pap Smear: ___________________________________________

TO BE COMPLETED BY HEALTH CARE PROVIDER
(M.D., D.O., OR QUALIFIED R.N.)

Height: _______ Weight: _______ T _______ P _______ R _______ BP _________
Vision: OD _______ OS _______ OU _______ With Correction: _______ WO: _________
Urine WNL? Yes _______ No _______ (Specify) _________________________________
Skin: _________________________ Hair: ___________________ Nails: __________________
Eyes: ___________________ Ears: ___________________ Nose: ______________ Throat: ___________________
Lungs: ______________________________ Heart: ___________________________
Abdomen: ___________________________________________________________________
Neck: _______________________ Spine: ____________________ Joints: _______________
Muscles: _______________________________ Neuro: _______________________________
Mental Status/Emotional Health: _________________________________________________
Any restrictions, learning disabilities, use of mobility aids? ________________________

Name of Examiner, Credentials (Please Print) ____________________________ Date __________
_________________________________________ (Signature of Examiner, Credentials)
_________________________________________ (Contact Information)

IMMUNIZATION RECORD  Proof of immunity is required prior to the start of clinical nursing courses. Please have this form completed and return it to Muskingum University, Department of Nursing, 163 Stormont St., New Concord, OH 43762.

Part I – TO BE COMPLETED BY STUDENT
Name: ___________________________________________ (Last) (First) (Middle Initial)
Date of Birth: __________ Social Security #: _____ - _____ - _____ Phone: (____)
 mm/dd/yyyy
Address: _______________________ City: _______________ State: ___ Zip Code: _________
Check Track: _____ Traditional: _____ RN-BSN Completion  Date of Enrollment: __________
 mm/dd/yyyy

Part II – TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER
(Dates Must Include Month and Year)

A. TETANUS, DIPHTHERIA, Pertussis (Tdap) must have evidence of two doses:
Dose #1 ___________ Dose #2 ___________
 mm/dd/yyyy mm/dd/yyyy
B. TETANUS-DIPHTHERIA (Td)
1. ☐ Received tetanus-diphtheria booster within the last 10 years . . . . . mm/yyyy

C. M.M.R. (Measles, Mumps, Rubella)
1. ☐ Dose 1 – Immunized at or after 12 months and before 5 years . . . . . mm/yyyy
2. ☐ Dose 2 – Immunized at 5 years or later . . . . . . . . . . . mm/yyyy

D. MEASLES (Rubella) If you did not receive MMR check appropriate box.
1. ☐ Had disease; confirmed by office record . . . . . . . . . . . mm/yyyy
2. ☐ Born before 1957 and therefore considered immune . . . . . . . mm/yyyy
3. ☐ Has report of immune titer. TITER REQUIRED (copy of lab report required). . . . . . . . . . . . . . . . . . . . mm/yyyy
4. ☐ Immunized with live measles vaccine at or after 12 months. . . . . . mm/yyyy

E. RUBELLA – check appropriate boxes.
1. ☐ Report of Rubella immune TITER REQUIRED (copy of lab report required). Specify date of titer. . . . . . . . . . . . mm/yyyy
2. ☐ Immunized with vaccine at or after 12 months or if immune titer is low. . . mm/yyyy

F. MUMPS – If you did not receive MMR, check appropriate box.
1. ☐ Had disease; MUST BE CONFIRMED BY TITER. TITER REQUIRED (copy of lab report required). Specify date of titer. . . . . . mm/yyyy
2. ☐ Immunized with vaccine at or after 12 months . . . . . . . . . mm/yyyy

G. VARICELLA (Chicken Pox) Check appropriate box.
1. ☐ Had disease; MUST BE CONFIRMED BY TITER. TITER REQUIRED (copy of lab report required).
   Specify date of titer . . . mm/yyyy Specify Results of Titer . . . Laboratory Results mm/yyyy
2. ☐ Immunized with vaccine at or after 12 months. . . . . . . mm/yyyy
H. TUBERCULOSIS - Check appropriate box.

1. □ PPD (Mantoux) test within the past year (Time or monovac NOT acceptable)
   Give date and test results . . . . . . . . . . . mm/dd/yyyy

2. □ Positive PPD – Chest x-ray REQUIRED.
   Give date and results of chest x-ray ______________________________ results
   Treatment: _______ Date started: ____________ COMPLETED: _____________ (mm/yyyy)

3. □ Had BCG vaccine – □ Yes ____________ (mm/yyyy) □ No

I. HEPATITIS
1. Completed Series □ YES Dose 1: _______ Dose 2: _______ Dose 3: _______
   mm/yyyy mm/yyyy mm/yyyy

   □ NO

J. INFLUENZA (Note: these vaccines may not be available at the time of assessment. The student may provide evidence of vaccine once they become available.)
1. Seasonal Flu □ YES ____________ □ NO mm/yyyy

2. H1N1 □ YES ____________ □ NO mm/yyyy

Health Care Provider (M.D., D.O., R.N., etc)

Name: ____________________________________________ (please print)
Address: __________________________________________
CSZ: _____________________________________________
Signature: _________________________________________ Phone: ___________________________

Original Publication July 2009 EFH
Updated September 2010 EFH/dmk
Desktop/dkeaton/Student Handbook/forms