INDIANA UNIVERSITY SOUTH BEND
HEALTH AND WELLNESS CENTER
Vera Z. Dwyer College of Health Sciences

Health Requirements for Clinical Programs

For the protection of students and the patients with whom they will come in contact during training, all entering student must meet established health requirements. This documentation is due by established deadline. **Incomplete packets are not acceptable.**

Please print the Health Evaluation and Immunization Checklist forms, ensure all required and applicable documentation is attached, and scan the documents to the IUSB Health and Wellness Center (IUSB HWC): iusbhwc@iusb.edu or drop off copies off at IUSB HWC.

*PLEASE NOTE – When corresponding via email, include full name, program, and graduation class in subject line.

1. Health Evaluation Form: To be completed and signed by a licensed healthcare professional upon completion and any applicable laboratory testing.

2. Immunization Checklist Form: Copies of clinical records MUST be attached for each vaccine or lab test to be considered VALID.
    a. Hepatitis B – The vaccine is administered in a series of 3 injections at 0, 1, and 6 months or two doses (Heplisav-B) one month apart. Students admitted at least 6 months prior to the beginning of classes must provide documentation of completion of either series OR proof of an immune Hepatitis B antibody titer. Students admitted later must at least provide documentation of starting the series prior to attending class. All students must show evidence of having begun the series at the time this form is due.
    b. Measles, Mumps, Rubella (MMR) – Proof of 2 vaccinations at least 28 days apart OR proof of an immune MMR antibody titer for each disease is required. *If you have received individual vaccinations for Measles, Mumps, or Rubella, proof of 2 vaccinations for each individual disease is required.*
    c. Tetanus/Diphtheria and Pertussis (Tdap) – Must be within ten years. If Tdap you submit expires before you graduate, you must get another Tdap.
    d. Varicella (Chicken Pox) – Proof of 2 vaccinations at least 28 days apart, OR proof of an immune Varicella antibody titer is required. Having the disease as a child is NOT proof of immunity.

e. Tuberculosis – Prior to beginning classes, new students must have two-step Tuberculin Skin Test (TST), formerly referred to as a PPD, if there is no documentation proof of a positive TST in the past. One QuantiFERON Gold (QFG) may be substituted for the TSTs, if there is a known history of Bacille Calmette-Guerin (BCG) vaccination, an IGRA is preferred over TST placements. If there is a history of positive TST or QFG in the past, documentation of the positive TST or QFG, evidence of a chest x-ray (valid for 3 years) is required along with documentation of any medical treatment prescribed. A TB symptom questionnaire (attached) must also be completed and submitted with your documentation.

The following must be included on the TST documentation in order to be considered valid:

1. Date and Time of placement
2. Date and Time of reading (must be within 48-72 hours of placement)
3. Results recorded in "mm"
4. Placement/Read/Documentation signed by a certified medical personnel.

Example of valid documentation:

Date Placed	Time Placed	PPD Lot #	Exp. Date	Location	Placed By:	Date Read	Time Read	Results (mm)	Read By:
07/01/13	1501	123456	12/2015	LFA	RAF, RN	07/04/13	1246	0mm	TPW, LPN

Two-Step Must Follow Guidelines:

Step One:

- Administer first TST
- Review result
  - Positive – consider TB infected no second TST needed; evaluate for TB disease.
  - Negative – a second TST is needed. Retest in 1-3 weeks after first TST result is read.

Step Two:

- Administer second TST 1-3 weeks after first test
- Review Results
  - Positive – consider TB infected and evaluate for TB disease.
  - Negative – consider person not infected.

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Student Immunization Checklist

Name (Last, First): _____ Date of Birth: _____

University ID: _____ Email: _____

Sex/Gender: _____ Transgender : _____ Preferred Pronouns: _____

Address: _____ City: _____ State: ___ Zip Code: _____

Phone: _____ Program Start Date: _____

Declaration Statement: Indiana University Dwyer College of Health Sciences requires you to provide documentation of the following vaccinations. *Failure to submit the appropriate documentation may delay or prevent your ability to start the program*.

Copies of clinical records MUST be attached for each vaccine, dose, or lab test.

Hepatitis B: THREE doses are required OR a positive titer (HBsAb).

1. _____ 2. _____ 3. _____ Heplisav-B 1._____ 2._____

OR Evidence of Immunity
Hepatitis B Titer: _____

MMR (Measles, Mumps, Rubella): TWO doses are required at least 28 days apart OR a positive antibody titer (IgG) for each.

1. _____ 2. _____

OR Evidence of Immunity

Measles Titer: _____ Mumps Titer: _____ Rubella Titer: _____

Tdap (Tetanus, Diphtheria, Pertussis): ONE adult dose within the last ten years (if expires before graduating must receive another).

1. _____

Varicella (Chicken Pox): TWO doses are required at least 28 days apart OR a positive antibody titer (IgG) **Note – Having the disease as a child is not proof of immunity.

1. _____ 2. _____ OR Evidence of Immunity Varicella Titer: _____

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TB Questionnaire

TB Screening: Two PPD skin tests are required if no history of positive TST OR one IGRA blood test may be substituted. A TB questionnaire must be filled out for all.

*New students must have two completed Tuberculin skin tests (TST) if there is no documented proof of a positive TST in the past. The placement of the TSTs must be less than 7 days apart. DATE/TIME of TST placement, DATE/TIME of TST read within 48-72 hours, and results recorded in "mm" MUST be recorded on the attached documentation or it is NOT valid.

Have you had:
TB or a positive skin test?
An immune disease?
Taking steroids or cancer medications?
Received a live virus vaccine in the last two months?
Had preventative immunization for TB with BCG vaccine?
Had a recent viral infection?
Been in contact with anyone with active TB disease?

Are you currently experiencing the following signs or symptoms?
Productive cough longer than two weeks.
Blood in sputum.
Unexplained fever.
Shortness of breath.
Chest pain.
Unexplained weight loss.
Unexplained fatigue.
Loss of appetite.
Hoarseness.

Step One:

TB skin test given on(Date/Time): _____ Given By: _____Forearm: ____

TB skin test read on(Date/Time): _____ Read By: _____ Induration Size: __mm

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Step Two: (must be less than 7 days from Step One)

TB skin test given on (Date/Time): _____ Given By: _____ Forearm: _____

TB skin test read on (Date/Time): _____ Read By: _____ Induration Size: __mm

Positive History for TB Screening: If there is a history of positive TST or IGRA in the past, documentation/evidence of the positive result and evidence of any chest x-ray and medical treatment received must be provided. Also, for any new positive TST or IGRA, evidence of a chest x-ray is required along with documentation of any medical treatment prescribed. A TB question must also be completed.

- Positive PPD skin test of IGRA: _____
- Follow up treatment: _____

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Student Health Evaluation

Name (Last, First): _____ Date of Birth: _____

University ID: _____ Email: _____

Sex/Gender: _____ Transgender: _____ Preferred Pronouns: ____

Address: _____ City: _____ State: ___ Zip Code: _____

Phone: _____

*Please complete this section before your appointment with your physician or practitioner.

ADHD	Hay Fever	Rheumatic Fever
Allergies	Hearing Problems	Unexplained SOB
Anemia	Heart Trouble	Seizures
Anxiety	Heat Intolerance	Skin Disease
Arthritis	Hepatitis	Thyroid Disease
Asthma	High Blood Pressure	Tuberculosis
Back Injury/Disease	Histoplasmosis	Tumor/Cancer
Bleeding Tendency	Jaundice	Other
Chest Pain	Kidney Disease	
Chronic Pain Condition	Liver Disease	
Congenital Defects	Lung Disease	
Depression	Measles	
Diabetes	Migraine	
Eczema	Mumps	
Emphysema	Muscle Disease	
Eye Problems	Nervous Disease	
Fainting Spells	Pneumonia	
Frequent Headaches	Rectal Disease	

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Additional Questions		
Have you or do you use alcohol?		
Have you or do you use drugs (illicit)?		
Have you or do you use tobacco products?		
Have you or do you use vape products?		
Have you ever had a work-loss injury or illness?		
Are you, at present, under a doctor's care for any condition?		
Do you have chronic draining sores or infections?		
Military record with medical discharge (physical and/or emotional concerns)?		
Do you see a dentist regularly?		
Do you wear glasses?		
Do you wear contact lenses?		

Please comment on all YES answers above:

_____

Hospitalization, Surgeries, Injuries (list with date):

Date	Hospitalization, Surgery, Injury	Date	Hospitalization, Surgery, Injury

Medications:

_____

I, THE UNDERSIGNED, CERTIFY THE ABOVE ANSWERS ARE TRUE AND GIVE THE EXAMINING PRIMARY CARE PROVIDER PERMISSION TO SUBMIT A REPORT TO IUSB VERA Z. DWYER COLLEGE OF HEALTH SICENCES.

Student Signature: _____ Date: _____

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To Be Completed By Licensed Physician/Nurse Practitioner

Hearing:

Complete audiogram only if patient failed whisper test:

Hearing:	Right Ear	Left Ear
Record distance from patient at which forced whispered voice can first be heard:	_____ ft	_____ ft
Audiometric test record decibel loss at:	_____ Hz	_____ Hz

Vision (uncorrected or corrected):

	Left	Right	Bilateral
Acuity			
Peripheral			
Color (Normal or Abnormal)			

Based on this physical exam; student is determined to be physically and mentally able to attend clinical rotations.

Yes: _____ No (Explain): _____

Limitations: No: _____ Yes (Explain): _____

Licensed Healthcare Provider NPI#: _____

Signature: _____

Date: _____