

PVAMU COLLEGE OF NURSING MEDICAL REQUIREMENTS

MUST be COMPLETED PRIOR to ADMISSION TO THE COLLEGE OF NURSING - UPPER DIVISION

(Please take this form with you to your provider to ensure proper labs are drawn)

REQUIREMENT	DESCRIPTION / COMMENT
<p>Titers are good for 5 years</p> <p>MMR / Varicella</p> <p>Blood Titers (IGG) to test for immune status Full lab report with reference ranges required (Quantitative) Completion Due Date: Fall Admission: July 1st Spring Admission: January 6th.</p>	<p>Blood Titers are blood tests that test for immunity or active disease. MMR/Varicella, Hep B, and Hep C can be drawn simultaneously for testing. Start early with the titers.</p> <ul style="list-style-type: none"> Review lab results with healthcare provider If positive, no further action is needed If negative OR equivocal Obtain booster and follow up with titer 4 – 6 weeks (about one and a half months) later or Obtain series (two shots one month apart) – follow up with repeat titer 4 – 6 weeks (about one and a half months) later. If the titer remains negative after two vaccines – obtain a note from a physician.
<p>Hepatitis B (Antibody Lab Titer to test for immune status) Full lab report with reference ranges required (Quantitative) Completion Due Date: Fall Admission: July 1st Spring Admission: January 6th.</p>	<ul style="list-style-type: none"> Review lab results with healthcare provider If positive, no further action is needed. If negative OR equivocal Obtain booster and follow up with titer 4 – 6 weeks (about one and a half months) later or Obtain the Heplisav-B series (2 shots one month apart – follow up with repeat titer 4 – 6 weeks (about one and a half months) later. If titer remains negative after two vaccines – obtain a note from a physician
<p>Hepatitis C Blood Titer (HCV) to test for active disease status of Hepatitis C</p>	<ul style="list-style-type: none"> If negative result – no further action is needed If positive – treatment plan per health care provider
<p>TDAP (Tetanus, Diphtheria & Pertussis) Completion Due Date: Fall Admission: July 1st Spring Admission: Dec. 1st.</p>	<ul style="list-style-type: none"> Must have had within the last 10 years
<p>TB Testing – Annual Requirement Obtain initial test: May 1 – May 31st for Fall Admission Dec. 1 – Dec. 31st for Spring Admission</p>	<ul style="list-style-type: none"> 1-step skin test. If there is a positive result, follow up with a QuantiFERON Gold blood test or chest X-ray If born outside the US – obtain a chest x-ray – physician must acknowledge results. QuantiFERON Gold Blood test may be used in place of a skin test or chest x-ray. Use the CON History and Physical Exam Form (on the website)
<p>Physical Exam – Annual Requirement Complete: May 1 – May 31st for Fall Admission Dec. 1 – Dec. 31st for Spring Admission</p>	<div style="border: 1px solid black; padding: 5px;"> <p>Note: obtain the TB and Physical exam within the designated month; not earlier.</p> </div>
<p>Flu Shot- Annual Requirement Must be taken between Aug 30th and December 1st for Fall and planned Spring admission</p>	<ul style="list-style-type: none"> Documentation must include: <ul style="list-style-type: none"> Date on which vaccine was given Pharmacy or location where taken Lot number AND expiration date of lot number
<p>Meningococcal Vaccine</p>	<ul style="list-style-type: none"> Will be required for entrance into PVAMU if under the age of 22
<p>Health Insurance</p>	<ul style="list-style-type: none"> Must have documentation <u>with your name showing as being on the policy or verification letter from the company that you are covered.</u>
<p>Proof of Residency</p>	<ul style="list-style-type: none"> Birth certificate AND Driver's License or Passport or Green Card
<p>CPR</p>	<ul style="list-style-type: none"> Must be the BLS course per American Heart Association; online course or American Red Cross NOT accepted; Face to-face-to-face or hybrid course accepted
<p>COVID-19</p>	<ul style="list-style-type: none"> Pfizer or Moderna – 2 vaccines or Johnson and Johnson – 1 vaccine or Minimum of one booster or Bivalent booster accepted

Save all documentation in an electronic file for uploading to an electronic portal (CastleBranch). Upon admission, further information will be given regarding: Setting up a CastleBranch account, obtaining a drug screen, and background check (Failure to submit all documents by stated deadlines will result in provisional acceptance being rescinded)

(STUDENTS, PLEASE UPLOAD ALL 4 PAGES OF THIS FORM TO CASTLEBRANCH)

MEDICAL HISTORY FORM
Prairie View A & M University College of Nursing – Houston, Texas
 (Complete in December for Spring Admission and July for Fall Admission)

GENERAL INFORMATION (To be filled in by student)

DATE: _____

Name in full _____
LAST NAME FIRST NAME MIDDLE NAME

Local Address _____

Home Address _____

Email: _____ Phone Number: _____

Date of Birth _____ Place of Birth _____
MONTH / DAY/YEAR

Age _____ Gender _____ Marital Status _____ Citizenship _____

PERSONAL HISTORY (To be filled in by student)

Have you been addicted or treated for the abuse of alcohol or other substances within the past five (5) years? (You may answer no if you have completed and/or are in compliance with TPAPN for substance abuse). YES NO If yes, explain: _____

Have you, to the best of your knowledge, ever had any of the following: (yes or no). If yes please explain below this box.

<input type="checkbox"/> Anemia	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Psychotic Disorders
<input type="checkbox"/> Antisocial Personality Disorder	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Defects	<input type="checkbox"/> Seizures
<input type="checkbox"/> Back Problem	<input type="checkbox"/> Hernia	<input type="checkbox"/> Sexually Transmitted Disease(s)
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Skin Disorders
<input type="checkbox"/> Borderline Personality Disorder	<input type="checkbox"/> Major Depression	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Paranoid Personality Disorder	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Gastrointestinal Disorder	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Other

Explanation for conditions noted in the above box:

Have you had any serious illness, operations or injuries? ____ If yes, explain: _____

MEDICATION: Medications you are routinely taking including alternative medication and herbs: _

Allergies-medications, foods, **latex**, etc.: _____

Date Form Completed by student:

Date form reviewed by Healthcare Provider: _____

Licensed Healthcare Provider (Printed)

(Signature) M.D. | D.O. | P.A. | N.P. (Circle correct title) Other

ANNUAL PHYSICAL EXAMINATION FORM
Prairie View A & M University College of Nursing
6436 Fannin St., Houston, Texas 77030

Name in Full _____
LAST NAME FIRST NAME MIDDLE NAME

STUDENT ID # _____

To Be filled in by Health Care Provider:

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Please check abnormal or normal as appropriate. If any area(s) is (are) abnormal please describe in Remarks below.

Eyes & Vision	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Heart: Murmur	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Ears & Hearing	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Heart: Rhythm	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Nose	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Lungs	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Throat (Adenoids and Tonsils)	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Breasts	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Gums	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Abdomen	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Tongue	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Hernias	<input type="checkbox"/> Yes <input type="checkbox"/> No
Teeth	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Pelvis	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Sinuses	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Spine Posture	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Skin	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Upper Extremities	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Thyroid	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Lower Extremities	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Heart: Size	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Nutrition	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Heart Sounds	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		

Explain any abnormal findings in the physical examination: _____

Date _____

Licensed Health Care Provider: _____

Signature: M.D. D.O. P.A. N.P. (Circle appropriate title)

Students are required to have a physical exam annually while enrolled in the nursing program. Should a student become pregnant or experience any change in health status during the annual year of the physical examination, the Semester Coordinator must be notified, and an updated physical examination must be filed within two (2) weeks. Also, there must be a meeting with the Semester Coordinator to review requirements of course enrollment.

Complete TB Screening in December for Spring Admission and July for Fall Admission

For New Upper Division Nursing Students: (Students born outside the U.S. should have the QuantiFERON Gold Blood Test or chest x-ray instead of the skin tests.

One Step TB test must be completed and documented below

<u>TB Skin Test or CXR</u>	<u>Date given</u>	<u>Date read</u>	<u>Result</u>	<u>Signature of provider</u>
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Health Care Provider Signature and Printed Name

Address of clinic

*Once the TB assessment has been done, continuing students will need an annual PPD skin test or a chest x-ray must be done annually.

This form may be used to report TB testing. If a chest x-ray is done, health care provider needs to acknowledge findings on letter head. Full x-ray report needs to be submitted.

Students whether or not this page is used for your TB testing, **it must be uploaded with your History and Physical Exam form.** If your results are not documented on this page, then sign the following statement.

My TB testing results are included on a documentation form other than this one. Please refer to the uploaded results on the TB link.

Student Name Printed/Signature

Date

RE: Immunizations: Immunizations are to be uploaded to CastleBranch on a physicians, clinical or drug pharmacy form.