University of Pittsburgh School of Nursing
Pitt-Johnstown Campus
Annual Student Health Form

ALL INFORMATION MUST BE IN ENGLISH. THIS FORM REQUIRES A HEALTH CARE PROVIDER (PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT) SIGNATURE on Page 2.

PART I: Student INFORMATION

(ALL FIELDS MUST BE COMPLETED)

NAME: /_/ (LAST NAME) (FIRST NAME) (Middle Initial)

ADDRESS /
(STREET) (CITY/STATE/ZIP)

TELEPHONE: _____ E-MAIL: _____

Health Insurance (must be completed by student)

I verify that I carry, and will carry health insurance that will cover payment of treatment and follow-up procedures related to bloodborne pathogens, other potentially infectious materials, and any illness or injury that could occur during class or clinical.

Student Signature (MONTH/DAY/YEAR)

PART II: TB Screening Information (Health Care Provider must Complete)

TB Screening: One of the following is required

1. TUBERCULOSIS SKIN TEST **2 step skin testing required**	1st Test: Date Test Read RESULT:_____ 2nd Test: Date Test Read Result:_____
OR TUBERCULOSIS QUANTIFERON GOLD BLOOD TEST	1. Date Read Test 1: / / 2. RESULT: ☐ POSITIVE ☐ NEGATIVE
CHEST X-RAY (If there was a positive TB test, at the time of this health screen or in the past, the results of the follow-up chest x-ray must to be reported and the attached symptom checklist must be completed	1. Chest X-Ray Date: / / 2. RESULT: ☐ NORMAL ☐ ABNORMAL

TDAP **(Primary series completed within past 10 years or tetanus booster within past 10 years)**	Date of last booster/or series completed:_____

PART III: EXAM EVALUATION AND VERIFICATION/ PROVIDER INFORMATION

(HEALTH CARE PROVIDER TO COMPLETE)

I have obtained a health history, performed a physical examination. In my opinion, this student is able to fully participate in the School of Nursing program:

If this student is NOT fully able to participate, please comment on activity limitations:

Name:

Signature:

Date / /

Phone:

Note: ALL SECTIONS ON THIS FORM MUST BE COMPLETED BEFORE ITS SUBMISSION! Upon completion, this form should be scanned and uploaded by the student to EXXAT. (Form Revised.: 9/2024 dmo)

Medical TB Questionnaire

Please answer the following questions about signs and symptoms of tuberculosis.

Are you coughing up blood-streaked sputum and/or having chest pain while coughing? ☐ YES ☐ NO Had you had a productive cough lasting longer than 3 weeks? ☐ YES ☐ NO Have you had unexplained night sweats, fever, or fatigue? ☐ YES ☐ NO Have you had unexplained loss of appetite or weight loss? ☐ YES ☐ NO