Please read the information in this packet carefully.

Note that Form 1, RN Nursing Student Health and Physical Form, should be mailed to the Medical Records Office. The address for Medical Records is Box 870374, Tuscaloosa, AL 35401.

All other paperwork should be mailed to Cynthia Morris at the Capstone College of Nursing. Her address is Box 870358, Tuscaloosa, AL 35487. If you have questions regarding any of the health requirements please contact Cynthia Morris at cmorris@ua.edu or 205-348-6639.
HEALTH REQUIREMENTS AND OTHER DOCUMENTATION
Required for RN Mobility Students

1. Health and physical exam form (Form 1)
2. Immunization form requiring verification of completed immunizations (Form 2)
3. Completed TB skin test documentation (Form 3)
4. Proof of completion of OSHA Training (The OSHA training can be completed by watching a PowerPoint at http://nursing.ua.edu/osha.htm)
5. Proof of completion of OSHA respirator fit testing (required for some clinical agencies)
6. Substance Abuse Policy – read, sign and return attachments A and B
7. Proof of current CPR certification, valid for the period required to complete courses

Upon promotion to the upper division, RN students will be allowed to continue in nursing courses only if all mandatory requirements (1-7) are completed and received by the posted due date. Failure to provide the required documentation by the due date will result in the student being administratively withdrawn from all nursing courses.
RN Nursing Student Health & Physical Exam Form

Must be completed by a physician, physician’s assistant or certified registered nurse practitioner and returned prior to beginning the nursing portion of the RN Mobility Tracks. Back of form may be used for additional comments when necessary.

Mail to: Medical Records Office
Box 870374
Tuscaloosa, AL 35401

or Deliver to: Medical Records
Student Health Center
750 5th Avenue East
Tuscaloosa, AL 35487

NAME:_________________________________________ CWID #: ________________________________

1. Vision normal with glasses ( ) without glasses ( ) Color vision defective? No ( ) Yes ( )
(NOTE: Wearers of contact lenses should be advised to have a pair of glasses for alternate use.)

2. Hearing normal? No ( ) Yes ( ) Are tympanic membranes intact? No ( ) Yes ( )

3. Physical Examination (Comment on abnormalities on back of form.)

   Skin................................. Normal ( ) Abnormal ( ) Abdomen.........................Normal ( ) Abnormal ( )
   Head, Face, Neck.............. Normal ( ) Abnormal ( ) Endocrine System...............Normal ( ) Abnormal ( )
   Nose & Sinuses.................. Normal ( ) Abnormal ( ) Spine.............................Normal ( ) Abnormal ( )
   Mouth & Throat............... Normal ( ) Abnormal ( ) Neurologic.......................Normal ( ) Abnormal ( )
   Teeth............................... Normal ( ) Abnormal ( ) Genitalia.......................Normal ( ) Abnormal ( )
   Lungs & Chest................... Normal ( ) Abnormal ( ) Breasts.........................Normal ( ) Abnormal ( )
   Heart............................... Normal ( ) Abnormal ( ) Pelvic if indicated........... Normal ( ) Abnormal ( )
   Vascular System .............. Normal ( ) Abnormal ( ) Hernia..........................Absent ( ) Present ( )

4. Are there any known health problems that would affect progress in the nursing program or participation in clinical nursing activities? No ( ) Yes ( ) If so, please specify on back of form.

5. Are there allergies that could be exacerbated by clinical environment or activities? No ( ) Yes ( ) If so, please specify on back of form.

6. Is this person healthy? No ( ) Yes ( )

TO MY KNOWLEDGE, THE INFORMATION I HAVE SUPPLIED ON THIS HEALTH FORM IS ACCURATE AND COMPLETE.

______________________________
Signature of Physician, Physician’s Assistant or Certified Registered Nurse Practitioner

______________________________
Date
**RN Nursing Student Immunization Form**

Form must be completed by a physician, physician’s assistant or certified registered nurse practitioner and returned prior to beginning the nursing portion of the RN Mobility Tracks.

Mail to: Capstone College of Nursing  Office of Nursing Student Services  Box 870358  Tuscaloosa, AL 35487-0358

NAME: ____________________________  CWID#: ___________________  DOB: ___________________

<table>
<thead>
<tr>
<th>IMMUNIZATIONS</th>
<th>DATES</th>
<th>DATES</th>
<th>DATES</th>
<th>DATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose 1</td>
<td>Dose 2</td>
<td>Dose 3</td>
<td>Booster</td>
<td></td>
</tr>
<tr>
<td>Tetanus (DPT series and TD/Tdap booster in last 10 years)</td>
<td></td>
<td></td>
<td></td>
<td>Required Tdap:</td>
</tr>
<tr>
<td>Meningococcal Vaccine (1 dose) (strongly recommended but not required)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Varicella¹ (2 doses)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>MMR ²,³ (2 doses)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Flu Vaccine (attach documentation)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

¹ Evidence of immunity required. Varicella Titer Date: _________________________ (attach lab report) If no evidence of immunity 2 doses of Varicella required.

² If born after 1956, >1 MMR after 1980 is required.

³ If no documentation of MMR, complete the following:

<table>
<thead>
<tr>
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<tr>
<td>Measles</td>
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<td></td>
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</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Rubella¹</td>
<td></td>
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</tbody>
</table>

If no documentation of Rubella immunization, complete Rubella titer (must be >1:10). Result: _________________________

<table>
<thead>
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<th>DATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose 1</td>
<td>Dose 2</td>
<td>Dose 3</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B (3 doses must be completed prior to beginning the first nursing course)</td>
<td>(one month after dose 1)</td>
<td>(4-6 months after dose 1)</td>
<td></td>
</tr>
</tbody>
</table>

NOTE: Students who are pregnant or lactating should postpone Hepatitis B Vaccination until completion of pregnancy or lactation.

Name of Physician, PA or Certified Registered Nurse Practitioner  Signature  Date
(Please Print) and official stamp (REQUIRED)
RN Nursing Student TB Skin Test Documentation

To be completed by a registered nurse and submitted annually while enrolled in the nursing program. Back of form may be used for additional comments when necessary.

NAME_____________________________________CWID #:  _______________

Tuberculin Skin Test:* Place skin test and read 48 hours later.

Date Tested ___________ Date Read ____________ Results ________________________

If positive, annual chest X-ray and report are required.

Registered Nurse Signature      Date

You must have up to date TB skin test results on file while a student at CCN. If your skin test expires while you are still enrolled you are responsible for providing updated documentation to the ONSS.