THE UNIVERSITY OF ALABAMA
CAPSTONE COLLEGE OF NURSING

HEALTH REQUIREMENTS AND OTHER DOCUMENTATION
Required for RN Mobility Students

1. Health and physical exam form (Form 1)

2. Student Immunization form requiring verification of completed immunizations (Form 2)

3. Completed TB skin test documentation (Form 3)

4. *Student OSHA Training Verification (Form 4)

5. **HIPAA Acknowledgement (Form 5)

6. State Authorization Acknowledgement (Form 6)

7. Substance Abuse Policy – read, sign and return attachments A and B

8. Copy of current CPR certification, valid for the period required to complete courses

9. Documentation of OSHA respirator fit testing (required for some clinical agencies)

Upon promotion to the upper division, RN students will be allowed to continue in nursing courses only if all mandatory requirements (1-9) 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 Failure to provide the required documentation by the due date will result in the student being **administratively withdrawn** from all nursing courses.

*The OSHA training can be completed by watching a PowerPoint at http://nursing.ua.edu/osha.htm
**The HIPAA training can be completed by visiting https://hipaa.ua.edu/

FORM 1

THE UNIVERSITY OF ALABAMA
CAPSTONE COLLEGE OF NURSING

Health & Physical Exam Form

Must be completed by a physician, physician's assistant or certified registered nurse practitioner and returned by the posted due date. Back of form may be used for additional comments when necessary.

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

FORM 2

THE UNIVERSITY OF ALABAMA
CAPSTONE COLLEGE OF NURSING

Immunization Form

Must be completed by a physician, physician's assistant or certified registered nurse practitioner and returned by the posted due date.

NAME: ______________________________________CWID#:___________________DOB:_______________________

IMMUNIZATIONS	DATES	DATES	DATES	DATES
	Dose 1	**Dose 2**	**Dose 3**	**Booster**
Tetanus (DPT series and TD/Tdap booster in last 10 years)				Required Tdap:
Meningococcal Vaccine (1 dose) (strongly recommended but not required)		NA	NA	NA
Varicella[1] (2 doses)			NA	NA
MMR[2,3] (2 doses)			NA	NA
Flu Vaccine (attach documentation)		NA	NA	NA

[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:

	DATES	DATES	DATES	DATES
	Dose 1	**Dose 2**	**Dose 3**	**Booster**
Measles				
Mumps				
Rubella[3]				

[3]If no documentation of Rubella immunization, complete Rubella titer (must be >1:10).
Result: _______________________

	DATES	DATES	DATES
	Dose 1	**Dose 2 (one month after dose 1)**	**Dose 3 (4-6 months after dose 1)**
Hepatitis B (3 doses must be completed prior to beginning the first nursing course)			

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)

FORM 3

THE UNIVERSITY OF ALABAMA
CAPSTONE COLLEGE OF NURSING

TB Skin Test Documentation

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.

FORM 4

THE UNIVERSITY OF ALABAMA
CAPSTONE COLLEGE OF NURSING

OSHA Training Verification

My signature indicates I have reviewed the OSHA training used by the Capstone College of Nursing.

____ ____________________
Signature Date

FORM 5

THE UNIVERSITY OF ALABAMA
CAPSTONE COLLEGE OF NURSING

HIPAA Acknowledgement

I attended The University of Alabama's training session on the requirements for ensuring the privacy of patients' protected health information under the Health Insurance Portability and Accountability Act (HIPAA).

I understand what protected health information is, and have been informed of the civil and criminal penalties for unauthorized disclosure of protected health information.

I understand that I am responsible for keeping protected health information from unauthorized disclosure, and that I will not share any patient's or client's protected health information with anyone who is not engaged in treatment, payment, or healthcare operations, unless authorized by the Privacy Officer in the organization where I am assigned. I also agree that I will not access any patient's protected health information unless I have a legitimate need to know that is related to my assignment.

I understand that I am responsible for learning the particular policies and procedures of the clinical agency where I have been placed. I also understand that I am subject to the sanctions those clinical agencies may impose for a breach of confidentiality. I also understand that my failure to abide by the agency's policies and procedures related to confidentiality of protected health information and could result in a variety of academic and/or disciplinary sanctions, up to and including dismissal from my academic program.

Signature: ____

Printed Name: ____

Date: ______________________ CWID: ___________________

FORM 6

THE UNIVERSITY OF ALABAMA
CAPSTONE COLLEGE OF NURSING

State Authorization Acknowledgement

Student Name: ________________________________ CWID: ________________________

I understand I must notify the Capstone College of Nursing (CCN) for changes to any of the following.

- State of residency
- State of licensure

I understand that if I relocate to a state where the CCN is not authorized to provide distance education I may have to withdraw from the program.

____ ________________________
Student Signature Date