RUTGERS
School of Nursing | Camden

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RUTGERS CAMDEN SCHOOL OF NURSING STUDENT HEALTH RECORDS PACKET

Attached is your "**Health Records**" packet, which Rutgers University, Camden, School of Nursing requires be completed prior to starting the Clinical Component of the WOC Nursing Program. **Please note that you cannot attend clinical experiences** if your health records are incomplete or not on file with Certified Background Check.

You should complete these requirements as soon as possible due to the amount of time involved in obtaining titers and scheduling immunizations.

You may get your physical done at your primary healthcare provider or Rutgers Camden Student Health Services provides physical examinations by appointment. For more information, please visit their website at http://healthservices.camden.rutgers.edu or call them at 856-225-6005 to schedule an appointment.

All students are required to submit proof of annual PPD (or chest x-ray) as well as, proof of annual influenza immunization, annually, by prior to Clinical.

You must submit all health record forms even though you may be receiving the Hep B injection series (the series must be completed before the beginning clinical).

YOU MUST USE THE FORMS SUPPLIED IN THIS PACKET; NO SUBSTITUTIONS!

PLEASE UPLOAD THIS FORM ONCE COMPLETED TO YOUR WOCNEP STUDENT TRACKER AT:

CERTIFIEDBACKGROUND.COM USING THE LOGIN INSTRUCTIONS SENT TO YOU BY YOUR FACULTY

Name:_____ **RUID:**_____

Rutgers School of Nursing
Physical Examination Record

☐ Traditional ☐ Accelerated ☐ RN/BS ☐ School Nurse ☐ WOC ☐ DNP ☐ Faculty

Permanent Mailing Address _____ Zip _____

Telephone # _____-_____-_____ Gender: Male☐ Female☐ Date of Birth____/_____/_____

PHYSICAL EXAMINATION REPORT – (Complete All Items)

Height_____ Weight_____ Blood Pressure_____ Pulse_____

Vision: with correction R 20/_____ L 20/_____without correction R 20/_____ L 20/_____

Findings: _____ is able to function in clinical experiences with the

	Normal	Abnormal	Description of Abnormal Findings
Appearance			
Nutrition			
Skin			
Head/Neck			
Glands			
Eyes			
Ears			
Nose			
Mouth/Teeth/ Throat			
Chest			
Lungs			
Heart			
Abdomen			
Back			
Extremities			
Testes			
Genitalia/Pelvic			
Neurological			

following restrictions: ☐ None ☐ Other_____

Signature_____☐ MD; ☐ DO; ☐ APRN _____Date

Provider address stamp

Name:_____ **RUID:**_____

Last, First MI

This section is to be 100% completed and signed by a licensed healthcare provider.

VACCINE	Dose #1 Date	Dose #2 Date	Dose #3 Date	Date of positive immune Titer
HEPATITIS B (ADULT) ***REQUIRED*** 3 doses followed by titer	__/___/___	__/___/___	__/___/___	☐ Titer attached
TDAP (Tetanus, diphtheria, and acellular pertussis) Dates of initial series and boosters (booster must be within past ten years	__/___/___ Date of most recent booster			
Varicella Physician documented history of disease, or 2 vaccinations, **or** positive titer attached. (Lab report required)	__/___/___	__/___/___	☐Documented History of disease ____/____/____	☐ Titer attached
MMR (Measles, Mumps, Rubella) Dates of 2 measles vaccines (measles or MMR) given after your first birthday; or physician documented disease; **or** positive blood titer attached for all these components.	__/___/___	__/___/__	☐Documented History of disease ____/____/____	☐ Titer attached
Polio Must have record of at least 3 vaccinations. Titers are acceptable in lieu of vaccinations.	__/___/___	__/___/__	__/___/___	☐ Titer attached
Meningococcal- Not needed unless living in Rutgers University Housing				

Healthcare Provider Name, Address and Signature, Degree

_____ _____/_____/____

Provider Signature and Degree **Date**

Provider address stamp

Return Form to:

Upload all completed health forms and titers to your Certified Background student tracker.

Name:_____ **RUID:**_____

Copy of the following lab results **must be attached** in addition to dates on lab page:

Required Titer:

- ☐ Hepatitis B Surface Antibody (4-8 weeks after final immunization)

A copy of lab result must be attached if no documentation of vaccine administration or documented disease:

- ☐ Rubella titer
- ☐ Rubeola titer
- ☐ Mumps titer
- ☐ Varicella -

***** There is no expiration on titers.**

Upload all completed health forms and titers to your Certified Background student tracker.

Name:_____ **RUID:**_____

Verification of Annual Influenza Immunization Administration

NAME_____ RUID_____

Influenza vaccine

TO BE COMPLETED BY HEALTH CARE PROVIDER:

Date Vaccine Administered _____/_____/_____

Vaccine Manufacturer: GlaxoSmithKline; Other _____

Vaccine Lot Number _____ Expiration Date: _____

Site of Injection: ☐ Left ☐ Right DELTOID Route: IM

Record any reaction observed in the first 20 minutes after vaccination administration:_____

Provider Signature/Date:_____/_____/_____

Provider address stamp

Upload all completed health forms and titers to your Certified Background student tracker.

Name:_____ **RUID:**_____

Verification of Annual PPD Administration

PPD Skin Test Information A one-step PPD is required unless you have documentation of a negative PPD in the past 12 months OR quantiferon blood test OR T-Spot test.

TO BE COMPLETED BY HEALTH CARE PROVIDER:
This section MUST be completed and signed by a licensed health care provider. Please provide the information below:

Date test administered (MM/DD/YYYY): _____

Date test read (MM/DD/YYYY): _____

Reading/Result in millimeters induration: _____

Date test administered (MM/DD/YYYY): _____

Date test read (MM/DD/YYYY): _____

Reading/Result in millimeters induration: _____

If PPD positive, complete TB questionnaire.
You will need to indicate date of conversion, post conversion chest X-ray and treatment received. Attach copy of clear chest X-ray report.
Also acceptable documentation for positive results includes documents from Health Services clearing the student.

Name of health care provider (printed): _____

Provider Signature/Date:_____/_____/_____

Provider's phone number: (_____)_____

Upload all completed health forms and titers to your Certified Background student tracker.

Provider address stamp