



RUTGERS

School of Nursing | Camden

School of Nursing-Camden
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RUTGERS SCHOOL OF NURSING - CAMDEN STUDENT HEALTH RECORDS PACKET

Nurses have a professional obligation to ensure patient safety. Attached is the required "**Health Records Packet**" that Rutgers School of Nursing - Camden requires to be completed prior to starting the Nursing Program. **Please note that you cannot attend lab/clinical experiences** if your health records are incomplete.

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

You may have your physical performed at your primary healthcare provider or Rutgers-Camden Student Health Services. Your primary healthcare provider or Student Health Services can provide a physical examination and blood work with a scheduled appointment.

Rutgers-Camden Student Health Services can also provide a "nurse review" of your Health Records Packet for completion. You are encouraged to take advantage of this service. For more information, please visit the Rutgers-Camden Student Health Services website at <http://healthservices.camden.rutgers.edu> or call them at 856-225-6005 to schedule an appointment.

All students are required to follow the Annual TB Screening Protocol. Proof of an annual influenza immunization is required by October 15th of each year.

Submit health records as they are completed. The Hepatitis B injection series may be submitted as you receive them.

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

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

WWW.CASTLEBRANCH.COM

USING THE LOGIN INSTRUCTIONS SENT TO YOU BY YOUR ADVISOR

PLEASE NOTE: All Rutgers University Immunization requirements for admission must be submitted to Student Health Services (MMR, Hepatitis B series, Meningitis-if living on campus, and TB if you are an international student). These are RU requirements and are needed in addition to scanning the documents into the CastleBranch Tracking System!

Name: _____

RUID: _____

**Rutgers School of Nursing-Camden
Physical Examination Record**

Traditional Accelerated RN/BS School Nurse WOCNEP DNP Faculty

Permanent Mailing Address _____ Zip _____

Telephone # _____ - _____ - _____ 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/____

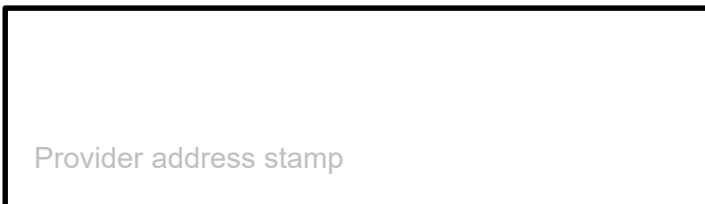
	Normal	Abnormal	Description of Abnormal Findings
Appearance			
Nutrition			
Skin			
Head/Neck			
Glands			
Eyes			
Ears			
Nose			
Mouth/Teeth/ Throat			
Chest			
Lungs			
Heart			
Abdomen			
Back			
Musculo-skeletal			
Testes (Optional)			
Genitalia/Pelvic (Optional)			
Neurological			

Findings: _____; Is able to function in clinical experiences with the

Following restrictions: None Other _____ Signature _____

MD; DO; APRN;
 PA

_____ Date



Name: _____

RUID: _____

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

Name: Last _____ First _____ MI _____ Birth Date: __/__/__

VACCINE	Dose #1 Date	Dose #2 Date	Dose #3 Date	Primary Immune Titers
HEPATITIS B REQUIRED 3 doses followed by primary titer; If primary titer negative/equivocal, Booster required	__/__/__	__/__/__	__/__/__	<input type="checkbox"/> Titer attached; __/__/__ Date of Titer
HEPATITIS B BOOSTER (Required if primary Hepatitis B titer negative/equivocal); <i>Follow-up with secondary titer or continue with repeat Hepatitis B vaccine series followed by secondary titer (see healthcare provider for appropriate recommendation.)</i>	__/__/__ Date of booster* <small>*Required if primary Hepatitis B titer negative/equivocal</small>			
VARICELLA Dates of 2 vaccines, or positive primary titer attached.	__/__/__	__/__/__		<input type="checkbox"/> Titer attached; __/__/__ Date of Titer
MMR (Measles, Mumps, Rubella) Dates of 2 measles vaccines (measles or MMR) given after first birthday; and positive primary titer attached; If primary titer negative/equivocal booster required followed by secondary titer	__/__/__	__/__/__	__/__/__ Date of booster* <small>*Required if primary MMR titer negative/equivocal</small>	<input type="checkbox"/> Titers attached; <input type="checkbox"/> __/__/__ Date of Titers
Tdap (Tetanus, diphtheria, and acellular pertussis) Date of most recent booster must be within past ten years	__/__/__ Date of most recent booster			

Healthcare Provider Name, Address and Signature, Degree

_____/_____/_____
 Provider Signature and Degree Date

Return Form to:

Provider address stamp

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

Name: _____

RUID: _____

PRIMARY TITERS TO BE INCLUDED IN HEALTH PACKET:

A copy of the following lab results/reports that show dates drawn

must be attached:

- Hepatitis B Surface Antibody
- Rubella titer
- Rubeola (Measles) titer
- Mumps titer
- Varicella – If you have documentation of the 2 vaccines, a titer is not required. If you have had a case of Varicella, you will still need either documentation of the 2 vaccines or a titer.

***** There is no expiration on titers; Negative or Equivocal titers require follow-up action. Please check with your care provider, Student Health Services, or Clinical Operations if you are not sure what action to take.**

SECONDARY TITERS THAT MAY BE REQUIRED AS FOLLOW-UP:

These titers may need to be performed as follow-up to an action that is performed as a result of a negative or equivocal titer. *These titers do not need to be included in this Health Packet*, but may be required as a Rutgers School of Nursing-Camden Compliance requirement. A copy of the lab results/reports must be uploaded to CastleBranch upon Completion. Secondary titers are due 4-6 weeks after a booster shot is administered.

- Hepatitis B Surface Antibody (4-6 weeks after booster or final immunization in REPEAT series)
- Rubella titer (4-6 weeks after booster)
- Rubeola (Measles) titer (4-6 weeks after booster)
- Mumps titer (4-6 weeks after booster)

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

Name: _____

RUID: _____

Initial Influenza Vaccination Requirement

Documentation of CURRENT seasonal Influenza Vaccination is required in order to participate in lab/clinical activities.

TO BE COMPLETED BY HEALTH CARE PROVIDER:

Date Vaccine Administered ____/____/____

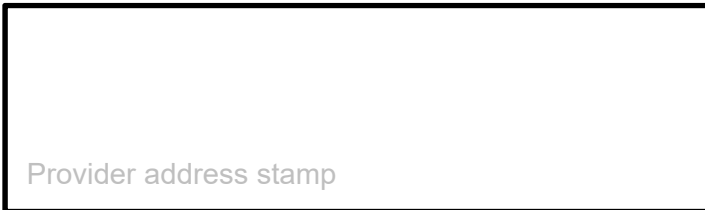
Vaccine Manufacturer: GlaxoSmithKline; Other _____

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: _____/_____/_____



Annual Influenza Vaccination Requirement: Documentation of a Seasonal Influenza vaccination administered between 08/22 and 10/31 is required each year in order to participate in lab/clinical activities. Documentation must include date administered, vaccine manufacturer, lot number, expiration date, site of injection, and provider signature. Documentation must be uploaded to CastleBranch annually by 10/31 each year.

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

Name: _____

RUID: _____

Initial Tuberculosis (TB) Protocol Requirement

A 2 Step TB Skin Test (PPD) 7-30 days apart **OR** a QuantiFERON Gold or T-Spot Blood Test is required to meet the Initial TB Protocol Requirement and to participate in lab/clinical activities.

If the result is negative, the renewal date for the Annual TB Protocol will be set for 1 year from the date of the initiation of testing.

If the result is positive, please provide a chest x-ray (lab report required) and make an appointment with Rutgers-Camden Student Health Services to complete a TB Questionnaire. Documentation of clearance for clinical from Rutgers-Camden Student Health Services is required.

The renewal date for the Annual TB Protocol will be set for 1 year from the date of Rutgers-Camden Student Health Services Clearance for Clinical.

Annual TB Protocol Requirement

The Annual TB Protocol Requirement must be followed in order to continue participating in lab/clinical activities.

If the Initial TB Protocol results were negative, a 1 step TB Skin Test (PPD) **OR** a QuantiFERON Gold or T-Spot Blood Test is required.

If the result is negative, the renewal date for the Annual TB Protocol will be set for 1 year from the date of testing.

If the result is positive, when it was previously negative, please follow the directions under "Initial TB Protocol Requirement" for a positive result.

If the **Initial TB Protocol results were positive**, please make an appointment with Rutgers-Camden Student Health Services to determine your future course of action and to complete a TB Questionnaire. Documentation of clearance for clinical from Rutgers-Camden Student Health Services is required in order to continue participating in lab/clinical activities.

Document results of Initial TB Protocol Requirement on Next Page.

Name: _____

RUID: _____

Initial TB Protocol

1. A two-step PPD is required (7-30 days apart).
or
2. A QuantiFERON Gold or T-Spot Blood Test

This section MUST be completed and signed by a licensed health care provider. Please complete **either** the PPD #1&2 **or** the Quantiferon Gold/T-Spot sections below.

Date PPD #1 administered (MM/DD/YYYY): _____	Signature _____
Date PPD #1 read (MM/DD/YYYY): _____	
PPD #1 Reading/Result in millimeters induration: _____	Signature _____

<small>(7-30 Days later)</small>	
Date PPD #2 administered (MM/DD/YYYY): _____	Signature _____
Date PPD #2 read (MM/DD/YYYY): _____ PPD	
#2 Reading/Result in millimeters induration: _____	Signature _____

OR

QuantiFERON Gold or T-Spot Blood Test Results (please circle test): _____
<input type="checkbox"/> Lab report attached; Date of test ___/___/___
Signature _____

If PPD or QuantiFERON Gold/T-Spot positive see instructions on page 6. Complete TB Questionnaire through Rutgers-Camden Student Health Services and Attach copy of chest X-ray report. Chest x-ray attached; Date of x-ray ___/___/___

Name of health care provider (printed): _____

Provider Signature/Date: _____/_____/_____

Provider's phone number: (_____) _____

Provider address stamp

Upload the completed Health Packet, titers, and related documentation to your CastleBranch student tracker.