

Student Health Services RN Pre-Matriculation Requirements

Please have your Primary Care Provider (PCP) perform a physical examination (page 7).
Please attach a copy of all required lab results (titers) as well as your immunization history with this form. Thank you very much!

Sincerely,
Paul Burke, BSN RN, Manager, Student Health Services – Geisinger College of Health Sciences

Verification of Information to be filled out by the Student:

The following statements are true to the best of my knowledge. I understand that any false statement made purposely may be grounds for dismissal from Geisinger College of Health Sciences

Statement of Confidentiality:

All medical records within Geisinger's Student Health Services are confidential and will not be released without written authorization from the student. For infection control purposes, I give my permission to have ONLY my immunization, titer and/or tuberculosis screening information forwarded for future participation in affiliated programs. This permission is in effect until I graduate or leave my program. I am aware that I may revoke this permission at any time. I also agree to allow for text messages or direct phone calls via the number I provide. I also agree to the creation of a Geisinger EPIC chart for continuity of care.

Signature

Date (MM/DD/YYYY)

Forms should be faxed to Student Health Services via secure fax:

570-214-1515 (recommended)

Or forms can be mailed to/dropped off at:

Geisinger College of Health Sciences

Attn: Student Health Services

525 Pine St.

Scranton, PA 18509

STUDENT HEALTH SERVICES REQUIREMENTS

The following information is required *prior to matriculation*.

If you are a current employee of the Geisinger Health System, you are not required to repeat the following health requirements on this page provided they are on file. Are you a current employee of Geisinger? _____ YES _____ NO

NECESSARY LAB WORK (TITERS) (REPORTS **REQUIRED** FOR THE FOLLOWING):

1. **Quantitative Hepatitis B Surface Antibody** (Qualitative results *will not* be accepted unless negative/non-reactive. If a positive/reactive Qualitative result is submitted, a new Quantitative test must be submitted)
 - All negative **Quantitative** Hepatitis B Surface Antibody results will require 1 additional booster dose and a repeat **Quantitative** titer 1-month after booster. If 2nd titer is again negative, entire 2 or 3 dose series must be completed with another **Quantitative** titer 1-month after conclusion of vaccine series. (Initial negative result will not hinder start date).

*****TITER RESULTS DO NOT HAVE TO BE RECENT*****

A Copy of your Health Insurance Card (submit to twaiabel@geisinger.edu)

PROOF OF VACCINES **REQUIRED** FOR THE FOLLOWING:

1. MMR – documented 2-dose vaccine series OR positive MMR lab titers.
2. Varicella - documented 2-dose vaccine series or provider documentation AND positive varicella titer if hx of chicken pox.
3. Tdap Vaccination within the past 10 years.
4. Hepatitis B vaccine series (2 dose Hepislab or 3 dose Energix). If vaccines are not available, you will need to repeat the entire vaccine series.

Tuberculosis Screening:

1. **Quantiferon Gold (IGRA) Lab Test** (dated within 1-year of matriculation – **lab result must be provided**) OR a 2-step PPD skin test (2 separate tests 1 week apart). A positive lab or skin test will require an attached copy of a chest x-ray dated after the test completed. Any positive chest x-ray will require physician documentation of follow-up treatment.

Creation of Geisinger EPIC electronic medical record for continuity of care.

In preparation for your time within the Geisinger footprint, we will require you to create a Geisinger EPIC chart, provided you don't already have one, for continuity of care.

An EPIC chart from another health care system will not suffice. If you are not sure if you have one or know you do not have one, please send the following information to:

Anna Richardson (Employee Health): adrichardson@geisinger.edu and please copy me on the email.

If you already have a Geisinger EPIC you do not need to complete/return this form. Do you already have a Geisinger EPIC chart? ____ YES

Name:

Address (local or home):

Phone number:

Email address (school or personal):

Date of birth:

Sex:

**TO BE COMPLETED BY STUDENT:
Pre-Matriculation Self-Health Assessment (2 pages)**

Student Name (Print) _____ Date of Birth _____

Self-Medical History: Select all that apply – use empty blocks for history not listed.

<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	Excessive weight gain	<input type="checkbox"/>	Phlebitis
<input type="checkbox"/>	ADHD	<input type="checkbox"/>	Excessive weight loss	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Gallbladder	<input type="checkbox"/>	Seizure Disorder
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Gout	<input type="checkbox"/>	STD's
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Hearing difficulty	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Skin Rash
<input type="checkbox"/>	Blood in Stool	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Chicken Pox (year _____)	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	Urinary Tract Infection
<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	Leg numbness	<input type="checkbox"/>	Visual Disturbances
<input type="checkbox"/>	Coughing up blood	<input type="checkbox"/>	Leg pain	<input type="checkbox"/>	Vomiting Blood
<input type="checkbox"/>	COVID-19 (when _____)	<input type="checkbox"/>	Leg swelling	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Loss of consciousness	<input type="checkbox"/>	
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	
<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	
<input type="checkbox"/>	Difficulty in urination	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	
<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	Persistent dizziness	<input type="checkbox"/>	
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Persistent headache	<input type="checkbox"/>	

Do you have any medical problems not listed above? ____ YES ____ NO

If yes, please list: _____

Student Name (Print) _____ Date of Birth _____

Please list surgical procedures (attach additional sheet if necessary)

Date	Procedure

Please list any hospitalizations (excluding the above - attach additional sheet if necessary)

Date (approx.)	Reason for hospitalization

Do you have any allergies? _____ YES _____ NO

If yes, please list below (attach additional sheet if necessary)

Allergen	Reaction

Are you taking any medication (prescription and OTC)? _____ YES _____ NO

If yes, please list and include dosage (attach additional sheet if necessary)

Medication	Dose, Route, Frequency

Do you smoke? _____ YES _____ NO (All Geisinger properties are smoke free)

TO BE COMPLETED BY A MEDICAL PROFESSIONAL (MD, DO, CRNP, PA-C)

Student Name (Print) _____ Date of Birth _____

Date of Physical Exam (*must be within 1-year of matriculation*): _____

	Normal	Abnormal	Not Examined	Remarks
Skin				
Hearing/Ears				
EOMS				
Vision/Eyes				
ENT				
Carotids				
Thyroid				
Lymph Nodes				
Lungs				
Heart				
Abdomen				
Musculoskeletal				
Neuromuscular				

Blood Pressure _____ / _____ Pulse _____ Height _____ Weight _____

Comments: _____

This patient is physically able to perform their assigned duties and is free of communicable disease. Also, based on the history and physical examination, this patient appears to be free from habituation or addiction to alcohol or other substances which may alter their behavior.

Provider Signature Provider Name (Print)

Address Phone