Logo, company name

Description automatically generated

***Practical Nurse Program***

***Health Appraisal Form***

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Student ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Please Print)**

Serenity Health Training Institute, in keeping with the rules and regulations of the State Board of Nursing and health care affiliates, requires nursing students to complete certain admissions health screening procedures. If you have any questions relating to the requirements, please call the Admissions Officer at (248) 828-6562.

**FORM INSTRUCTIONS**

All students are required to provide health history information and to have a health evaluation prior to admission to the Practical Nurse Program at Serenity Health Training Institute.

**THIS HEALTH FORM MUST BE COMPLETED BEFORE STUDENTS CAN BE ADMITTED INTO THE PROGRAM.**

Please check the health form for completeness before submitting it to the school and make a copy of the form for your records. Return form to:

**Serenity Health Training Institute**

**Admissions Department**

**20245 W 12 Mile Road STE: 217**

**Southfield, Michigan 48076**

**(248) 828-6562**

* The use of any corrective materials (white-out/correction fluid) or heavily crossing out entries may suggest the altering of a medical record, which is illegal, and this form will be regarded unacceptable. If corrections are needed draw a single line through the error, initial and make corrections needed, or you may request a new form for completion.
* Lab results that are submitted without requested documentation on form, or use of other health evaluation forms (e.g. work physicals), will not be accepted.
* Please print unless otherwise indicated. All date fields required by this form must be legible and completed with **Month, Day and Year Values.** Failure to comply with these requests will prevent your application from being processed.

**DISABILITY INFORMAITON**

If you have a health problem that may require individualized disability support services, it is **your** responsibility to contact the Nursing Director for the Practical Nurse Program at: (248) 828-6562

**HEALTH INSURANCE DATA**

**ATTENTION: ALL NURSING STUDENTS**

**It is advised that you carry and be prepared to show evidence that you have current health insurance. This is highly recommended for the entire duration of your program. This health insurance must cover you for any treatments related to bloodborne pathogens, other potentially infectious materials, and any illness or injury that could occur during class or clinical. If you do not have health insurance, you will be responsible for any treatment and cost incurred during class or clinical externship times.**

**(ALL AREAS MUST BE COMPLETED BY STUDENT)**

I verify that I have read and understand all information listed above.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Student ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please Print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

(Student signature) Month Day Year

**PART I: STUDENT INFORMAITON**

**(ALL AREAS MUST BE COMPLETED BY STUDENT)**

Student Social Security Number \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Gender? Male Female (circle one)

Name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Name) (First Name) (Middle)

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street) (City) (State) (Zip Code)

Emergency Contact Information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Contact Name) (Relationship)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Contact Address) (Contact Phone Number)

**CONFIRMATION OF ABILITY TO FULLY PARTICIPATE IN THE NURSING PROGRAM**

**(STUDENT TO COMPLETE)**

**Part II:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_do not have any physical or behavioral issues which could interfere with my abilities to perform in the classroom or at a clinical externship site. If my condition changes, I will notify the nursing director.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Student Signature) (Date)

I understand that the following functions are essential to the successful progression in and completion of the nursing program requirements. My initials acknowledge my ability to fully participate in the program.

|  |  |  |
| --- | --- | --- |
| Function | Description / Standards | Initial/date |
| Interpersonal Skills | Ability to interact appropriately with diverse individuals, families and groups. |  |
| Communication Skills | Communicates effectively in English in verbal and written form. |  |
| Motor Skills | Gross and fine motor skills sufficient to provide safe, effective nursing care. |  |
| Critical Thinking | Ability to exercise sound nursing judgment and problem solving. Long hours for studying nursing materials. Work under stressful conditions. |  |
| Hearing | Auditory ability enough for assessing and monitoring client needs. |  |
| Tactile | Ability to accurately assess and monitor client needs. |  |
| Visual | Ability to accurately assess and monitor client needs. |  |
| Emotional Stability | Ability to assume responsibility/accountability for my actions. |  |

**Serenity Health Training Institute**

**Practical Nurse Program**

**HEPATITIS B DECLINATION FORM**

**(To be completed by student)**

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. It has been recommended that I receive the Hepatitis B vaccine.

\_\_\_\_\_\_\_\_\_\_I have already received the Hepatitis B series vaccination.

\_\_\_\_\_\_\_\_\_\_\_NO, I decline the Hepatitis B vaccination at this time. I realize that by declining this vaccine I continue to be at risk for acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can receive it and notify the school with the proper documentation.

Student Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART III: Titer and Vaccination Explanations**

**PLEASE READ CAREFULLY**

Serum titers are blood tests that measure whether you are immune to a given disease(s). More specifically a quantitative serum titer is a titer with a numerical value indicating your actual degree of immunity to a disease(s). The clinical sites you may visit or be assigned to require documented proof of immunity in the form of quantitative titers. Simply getting the vaccination is not enough. Therefore, when titers are drawn, they must be quantitative titers, and you must provide copies of the laboratory results containing the numerical values for Mumps, Measles, Rubella, and Varicella. **Have your titers drawn first.** If the titer indicates you are non-immune, then you need to be vaccinated or re-vaccinated for the specific disease in question. Titers should be drawn again in 4-6 weeks after vaccination is completed.

**\*\*\* You are also required to have an updated TDaP, Flu Vaccine, and TB Test or CXR.**

**Students are reminded that documentation of current vaccinations /immunizations and or immunity is mandatory prior to acceptance in the nursing program.**

**The coronavirus vaccine is required. We follow CDC, State of Michigan and Oakland County Health Department guidelines for COVID 19. Anyone testing positive will have to quarantine for 10 days and see the school director for further instructions.**

**Failure to complete the mandatory vaccinations required for the Practical Nurse Program will deem you ineligible for the program.**

**Should you or your physician have any questions or concerns please feel free to contact the Admissions Office.**

**(248) 828-6562**

Student Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LABORATORY & DIAGNOSTIC TEST DATA**

**(HEALTH CARE PROVIDER TO COMPLETE)**

**Clinical/externship contracts require that you must have titers drawn for Rubeola, Rubella, Mumps and Varicella, to determine if you are immune, regardless of prior illness or immunization history. A copy of your titer results must be provided to the school prior to your acceptance.**

**If titers were drawn in the past and showed that you were non-immune, you will need a MMR and Varicella booster. If it has been longer than 6 months since the booster, you will need another titer(s) to see if the immunization has provided immunity.**

**\*\*\* IF NON-IMMUNE, PLEASE GIVE CURRENT BOOSTER AND DATE ADMINISTERED**

**IF EQUIVOCAL, YOU ARE CONSIDERED TO BE NON-IMMUNE UNTIL ANOTHER TITER PROVES**

**OTHERWISE.**

**IMMUNIZATION RECORD**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Requirement** | **Completion Date** | **Expiration Date** | **Titer Date** | **\*Re-vaccination Date** |
| **MMR**  **(Booster if titer demonstrates need)** |  |  |  |  |
| **VARICELLA**  **(Booster if titer demonstrates need)** |  |  |  |  |
| **TDaP** |  |  |  |  |
| **FLU** |  |  |  |  |
| **TB TEST or Chest X-Ray** |  |  |  |  |
| **\*PNEUMONIA** |  |  |  |  |
| **\*HBV (HEP B)** |  |  |  |  |
| **Other** |  |  |  |  |
| **Coronavirus Vaccine is required** |  |  |  |  |

**\* Only if deemed required by physician or clinical externship site**

**Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TUBERCULOSIS SCREENING**

**(HEALTH CARE PROVIDER TO COMPLETE)**

**ALL SECTIONS ON THIS FORM MUST BE COMPLETED BEFORE ITS SUBMITTAL**

**PPD Skin Test**

Date Administered: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Month Day Year

Date Read: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

Results: Negative Positive (circle one)

**QuantiFERON-TB Gold Blood Test**

Date: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

Month Day Year

Results: Negative Positive (circle one)

**Chest x-ray required if positive result along with copy of x-ray report**

Chest x-ray date: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_ Results: Positive Negative

Month Day Year

**------------------------------------------------------------------------------------------------------------------------**

**PROVIDER INFORMATION**

**NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Please Print)**

**(Circle One) CRNP FNP MD DO RMA OTHER**\_\_\_\_\_\_\_

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_**

Month Day Year

**Phone Number (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PART IV: EXAM EVALUATION AND CONFIRMATION**

**(HEALTH CARE PROVIDER TO COMPLETE)**

**ALL SECTIONS ON THIS FORM MUST BE COMPLETED BEFORE ITS SUBMITTAL**

* I have obtained a health history, performed a physical examination and reviewed the student’s immunization status and required laboratory test. In my opinion this student is able to **FULLY** participate in the Practical Nurse Program at Serenity Health Training Institute.
* If this student is **NOT FULLY** able to participate, please comment on activity limitations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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(Statement of Limitations)

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**PROVIDER INFORMATION**

**NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Please Print)**

**(Circle One) CRNP FNP MD DO PA OTHER**\_\_\_\_\_\_\_

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_**

Month Day Year

**Phone Number (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**