Baptist Health System
School of Health Professions
When Caring is Your Calling

Congratulations on your acceptance to the Baptist School of Health Professions!!

You will be REQUIRED to clear with the Student Health Nurse **prior** to starting your program.

- ✓ **FIND YOUR IMMUNIZATION RECORDS…NO MATTER HOW OLD!**
- ✓ **COMPLETELY FILL OUT THIS PACKET.**
- ✓ **CALL (210) 297-9163 TO SCHEDULE YOUR HEALTH SCREENING APPOINTMENT.**
- ✓ **IT WILL TAKE APPROXIMATELY 45 MINUTES.**
- ✓ **BRING YOUR COMPLETED PACKET AND IMMUNIZATION RECORDS TO YOUR APPOINTMENT.**

List of required vaccines/ test:

- **Measles/Mumps/Rubella**: Two doses each of live measles and mumps vaccines; and at least one dose of live rubella vaccine; OR serologic confirmation of immunity to all three measles, mumps and rubella
- **Chickenpox (Varicella)**: Serologic confirmation of immunity; OR 2 doses of Varicella vaccines at least 28 days apart or documented history of disease.
- **Tetanus Diphtheria Pertussis**: One dose of vaccine within prior 10 years
- **Hepatitis B series**: A completed series (usually three shots over a 6 month period); OR serologic confirmation of immunity. **Accelerated shots/Fast track is not accepted.**
- **TB test x2**: **One within a year and one within 3 months of the health screening**. Two Tuberculin skin test results during the 12 months prior to screening, one of which needs to be within the past 3 months or TSPOT or IGRA within 3 month prior to screening. If you are not able to take a TB skin test due to a prior positive reaction or allergy, a negative/normal chest x-ray is required within the preceding 12 months.
- **Influenza**: Annual immunization against influenza, to include the seasonal vaccine as well as any other vaccines as designated by the Centers for Disease Control and Prevention, unless there exists a DOCUMENTED medical or religious contraindication.
- **Meningitis Vaccine:** Required for students 21 years and under. (RN, LVN, Radiology, Sonography, Surgical Technology programs only)
- **Drug Screen**: Drug Screen may be completed at your scheduled appointment time. Cost of the drug screen is your responsibility. Please bring ID.
- **Respiratory Mask Fit Test:** will be done at your health screening appointment.
  Note: a Respiratory Fit Test will not be done if you have facial hair that interferes with the seal of the mask.

If you are a previous student or are/were a Baptist Health System employee, please let me know at your appointment and we may be able to shorten the screening process!

Please be advised that failure to **complete** your screening or failure to maintain your annual health requirements will prevent you from participating in class and clinical rotations.

Karen Puguan RN, BSN, Health Nurse
kxpuguan@baptisthealthsystem.com
Student Health Services
(210) 297-9163

I acknowledge, understand & agree to the above Student Health requirements:
Print Name: _____
Sign Name: _____
Date: _____

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STUDENT HEALTH SCREENING

Please Print:

/ /

NAME: LAST, FIRST, MI | START DATE | LAST 4 SSN # | TELEPHONE #

PROGRAM | ALLERGIES | AGE / DATE OF BIRTH

In keeping with recommendations from CDC, OSHA and JCAHO, student health screenings are an important part of the registration process for SHP students. The purpose of these screenings is to promote health and safety; to prevent disease transmission from patient to student; and from student to patient, fellow students, BHS employees or visitors.
Bring your immunization record to the **Student Health Nurse** for review as soon as possible. If the documentation is not sufficient you may have blood tests/vaccines. Cost of tests/vaccines is your responsibility.

As a healthcare worker (HCW) you may be exposed to communicable diseases during the course of your workday. It is important that you learn and use proper techniques to prevent unnecessary exposures. Diligent use of Standard Precautions, personal protective equipment (PPE), and practicing proper hand hygiene (hand washing and hand sanitizing) before and after each patient contact, will provide protection against infection transmission.

Pregnant HCWs are at no greater risk of acquiring infectious diseases than are their non-pregnant co-workers. However, exposure to certain diseases can result in serious harm to the fetus, (e.g. CMV, hepatitis, herpes simplex, HIV, rubella, varicella) whether the infection is acquired in occupational or non-occupational environments. Like all HCWs at risk, pregnant women and women of childbearing age are expected to practice standard/transmission-based precautions for all appropriate tasks and all patients.

The BHS Employee/Student Health program consists of:

- Immunization screening, medical history/status, blood pressure, pulse, height, weight, color vision testing
- Vaccines/Immunity status: Hepatitis B, Tetanus/Diphtheria w/Pertussis (Tdap), Measles, Mumps, Rubella (MMR), Varicella (chickenpox), and Influenza (flu)
- Tuberculosis (Tb) screening/testing/surveillance
- Respiratory Fit Testing for the Respiratory Protection Plan
- Drug Screen

FOR STUDENT NURSE USE ONLY: : DATE TODAY _____

HT. = _____’_____”
WT. = _____lbs.
*BMI = _____
*BP = _____
PULSE = _____

RISK CAT. = _____

*If Hypertensive, BP info given and referred to MD by: _____

_____

- **MeaslesMumpsRubella** : #1_____#2_____
  - Titer_____
- **VARICELLA /CHICKEN POX**: #1_____#2_____
  Titer _____
- **TDAP** : _____ **Meningitis**_____ _____
- **Hep B** #1_____#2_____#3_____
  Titer_____
- **FLU SHOT** :_____
- **TB TEST**: __x1_____x2_____**TSPOT/IGRA**_____
- **CHEST X-RAY**: _____
- **RFT**: Passed / Failed:
  3M1870+ AURA, 3M 1860 Reg, 3M1860 SM, other_____
- **CVT**: 12, 8, 6, 5, 74, 2, 6, 5, 7, 26, 42
  Passed / Failed (Notify director)_____

- **Drug Screen**: Reactive / Negative / To MRO (Positive / Negative)

COMMENTS:
_____
_____

STUDENT HEALTH MEDICAL STATUS/HISTORY

PRINT: NAME **DATE**

Please **Check** the correct response for any current problems or history with the following items listed below.
If YES, give explanation in the space provided or comment section below:

CONDITION	YES	NO	CONDITION	YES	NO
HEART DISEASE:			SKIN SENSITIVITIES:		
BLOOD PRESSURE (HIGH/LOW):			VISION OR HEARING PROBLEMS:		
BLOOD/CIRCULATION DISORDERS:			ORTHOPEDIC/MUSCULAR:		
STROKE:			BACK INJURY/PAIN		
THYROID/METABOLIC:			GASTROINTESTINAL/DIGESTIVE		
RESPIRATORY/BREATHING/LUNGS:			TOBACCO USER? TYPE/AMOUNT:		
TUBERCULOSIS (SELF/CLOSE CONTACT):			HOSPITALIZATION(S):		
HEPATITIS (TYPE?)/OR HIV:			SURGERIES:		
KIDNEY/URINARY PROBLEMS:			FEMALE DISORDERS: (LAST MENSES):		
DIABETES (INSULIN/NON-INSULIN):			OTHER MEDICAL:		
LOW BLOOD SUGAR:			CONGENITAL ABNORMALITIES:		
NERVOUS SYSTEM/NEUROLOGICAL:			MILITARY DISCHARGE/DISQUALIFY FOR MEDICAL:		
SEIZURES/EPILEPSY:			PHYSICAL LIMITATIONS/RESTRICTIONS:		
CANCER:			WORK ACCIDENTS/INJURIES:		
HERNIA:			CURRENTLY IN GOOD HEALTH		
HEADACHES:			**CHICKENPOX DISEASE OR VACCINE**		
FAINTING SPELLS/DIZZINESS			**MEASLES, MUMPS, RUBELLA DISEASES/VACCINES**		
MENTAL HEALTH ILLNESS/ DISORDER:			**TDAP VACCINE <10 YRS**		

LIST CURRENT MEDICATIONS (Prescription & Over the Counter) DOSAGE REASON

_____

_____

_____

_____

☐ I am currently **not** taking any medications that would impair my judgment or ability to perform my activities. I will notify the Student Health Nurse if there are any changes in this information I have provided.

☐ I do not have limitations/restrictions at this time but I understand that I can request accommodations when the need arises and notify the school counsellor or the student health nurse.

COMMENTS:_____

_____

_____

_____

I verify that the preceding information is true, correct and complete.
I understand that any false, incomplete, or omitted information may result in rejection of my enrollment or in termination when discovered. I understand this form will be part of my confidential Student Health record.

_____

PRINT NAME **SIGNATURE** **DATE**

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[ ] BMC [ ] MTB [ ] NCB [ ] NBH [ ] SLB [ ]RHH [ ] TENENT/CONIFER/OTHER [ ] BSHP

Name: _____ **Date of Birth**: _____ **Program**_____

Home/Cell Phone Number: _____ **Allergies:** _____

Signs & Symptoms of Tuberculosis

□ Yes □ No Have you lost unexplainable weight in the last 6 months without dieting? If yes, how much? _____
□ Yes □ No Are you experiencing a loss of appetite? If yes, how long? _____
□ Yes □ No Do you on a regular basis have unexplainable night sweats or wake up with the sheets wet from sweating? If yes, how long? _____
□ Yes □ No Do you have a frequent persistent cough? If yes, how long? _____
□ Yes □ No Are you bothered by being tired all the time? If yes, how long? _____
□ Yes □ No Are you bothered by shortness of breath? If yes, how long? _____
□ Yes □ No Do you cough up blood? If yes, how long? _____
□ Yes □ No Have you been having increased temperature? If yes, how long? _____

Medical History

□ Yes □ No Have you ever had a positive TB Skin or blood test? If yes, year _____
□ Yes □ No Have you ever taken medication to prevent or treat TB, e.g., isoniazid (INH) or rifampin?
□ Yes □ No Have you ever had BCG vaccine? If yes, year _____
□ Yes □ No Have you ever had TB disease diagnosis? If yes, year _____
□ Yes □ No Have you had a live virus vaccine in the past 4 weeks? If yes, wait 4 weeks.
□ Yes □ No Have you had a recent viral illness? If yes, wait 2 weeks.
□ Yes □ No Are you taking immunosuppressive drugs? If yes, consider 5mm positive.
□ Yes □ No Do you have any health conditions or take medications that might affect your immune system (e.g. steroids, HIV/AIDS, organ transplant, chemotherapy, severe chronic illness) If yes, consider 5mm positive

Travel History

□Yes □ No Were you born in the US? If no, where? _____ When did you come to the US?_____
□Yes □ No Since your last screening, have you traveled outside the country? When/where/how long?_____

I understand if I should experience any of the signs & symptoms of tuberculosis above at any time during the year, I will contact Occupational Health immediately. I understand if the TB Skin test reaction is not read in 48 to 72 hours after its administration, it will have to be repeated. By signing this form I consent to receive a Tuberculin Skin Test, to comply with school requirement.

Student Signature: _____ **Date:** _____

********** **Student Health Nurse Only** **********

Last TB Test : _____ **Needs x1 x 2**

TST #1 : Manufacturer: Sanofi Pasteur Tubersol Lot #: _____ **Exp.:** _____ **Dose : 0.1 ML**

Site: Intradermal Forearm □ Right □ Left Administered by: *Karen Puguan BSN RN* **Date:** _____ **Time:**_____

Induration: _____**mm Read by:** _____ **Date:** _____ **Time:** _____

TST #2: Manufacturer: Sanofi Pasteur Tubersol Lot #: _____ **Exp.:** _____**Dose : 0.1 ML**

Site: Intradermal Forearm □ Right □ Left Administered by: *Karen Puguan BSN RN* **Date:** _____**Time:** _____

Induration: _____**mm Read by:** _____ **Date:** _____**Time:** _____

IGRA Date and Results:_____ **CXR Date:** _____ **CXR: □ Negative □ Positive**

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Name: _____ Last 4 SSN_____Program_____

Health Care Workers Respiratory N-95 Fit Questionnaire

(Required for all students)

Please answer the following:

1. Have you ever been told by a doctor that you have asthma, chronic bronchitis, emphysema, or other chronic chest condition?
   ☐ Yes _____ ☐ No
2. Do you have any breathing difficulties with normal work or other usual activities?
   ☐Yes _____ ☐ No
3. Have you been told by a doctor that you have angina, high blood pressure, or other heart abnormalities?
   ☐Yes _____ ☐ No
4. Do you have chest pains, skipped heart beats, lightheaded spells, or other symptoms you think are related to your heart?
   ☐Yes _____ ☐ No
5. Are you aware of any medical condition or other reason that you think would prevent you from wearing a respiratory protective device in your work? ☐ Yes _____ ☐ No
6. Has your present or past work involved wearing an isolation, surgical mask or respirator?
   ☐ Yes ☐ No
7. If the answer to question #6 is **"YES"**, have you ever had problems that have prevented you from wearing the device as required?
   ☐Yes ☐No

[ ] I acknowledge that changes in my facial features such as facial hair, weight-loss, fractures, scarring, etc. may affect the fit of the N-95 respirator and I should consult the occupational health nurse for a refitting**.**
Note a Respiratory Fit Test will not be done if you have facial hair that interferes with the seal of the mask. The individual will need to be clean shaven at the seal of the mask according to BHS policy to be fit tested and/or wear/use the N95 mask.

Student Signature: _____ Date: _____

**********FOR STUDENT HEALTH NURSE NURSE ONLY**********

QUALITATIVE FIT TESTING FOR N-95 PARTICULATE MASK:

☐ Saccharin ☐ Bitrex Threshold Check – Y N 10 20 30 Fit Test: ☐Pass ☐ Fail

Brand/Model: (Check one)

☐3M NIOSH N95 AURA 1870+, ☐3M NIOSH N95 1860 REGULAR, 3M NIOSH N95 1860 SMALL,

☐3M NIOSH N95 V-FLEX 1805, ☐ OTHER: _____.

[ ] Instructions for RFT use, donning, removal, fit check, storage and replacement indicators given at time of fit testing.

Student Health Nurse: _____ Date: _____

Comments:

_____

_____

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Documenting History of Illness: Varicella (Chickenpox)

This is to verify _____ had varicella disease (chickenpox)

(Name of student)

on or about _____and does not need the varicella vaccine.

(Approximate month/day/year)

_____

(Date)

_____

(Signature)

_____

(Printed name)

_____

(Relationship to employee/student)

Title 25 Health Services, 97.65 of the Texas Administrative Code states, “A written statement from a parent (or legal guardian or managing conservator), school nurse, or physician attesting to a child’s positive history of varicella disease (chickenpox), or of varicella immunity, is acceptable in lieu of a vaccine record for that disease.” If the student is unable to submit such a statement or serologic evidence, varicella vaccine is required.

Important Information about Bacterial Meningitis

This information is being provided to all new college students in the state of Texas. Bacterial Meningitis is a serious, potentially deadly disease that can progress extremely fast – so take utmost caution. It is an inflammation of the membranes that surround the brain and spinal cord. The bacteria that causes meningitis can also infect the blood. This disease strikes about 3,000 Americans each year, including 100-125 on college campuses, leading to 5-15 deaths among college students every year. There is a treatment, but those who survive may develop severe health problems or disabilities.

WHAT ARE THE SYMPTOMS?

- High fever
- Severe headache
- Rash or purple patches on skin
- Vomiting
- Light sensitivity
- Stiff neck
- Confusion and sleepiness
- Nausea
- Lethargy
- Seizures

There may be a rash of tiny, red-purple spots caused by bleeding under the skin. These can occur anywhere on the body.

The more symptoms, the higher the risk, so when these symptoms appear seek immediate medical attention.

HOW IS BACTERIAL MENINGITIS DIAGNOSED?

- Diagnosis is made by a medical provider and is usually based on a combination of clinical symptoms and laboratory results from spinal fluid and blood tests.
- **Early diagnosis and treatment can greatly improve the likelihood of recovery.**

HOW IS THE DISEASE TRANSMITTED?

The disease is transmitted when people exchange saliva (such as by kissing, or by sharing drinking containers, utensils, cigarettes, toothbrushes, etc.) or come in contact with respiratory or throat secretions.

HOW DO YOU INCREASE YOUR RISK OF GETTING BACTERIAL MENINGITIS?

- Exposure to saliva by sharing cigarettes, water bottles, eating utensils, food, kissing, etc.
- Living in close conditions (such as sharing a room/suite in a dorm or group home).

WHAT ARE THE POSSIBLE CONSEQUENCES OF THE DISEASE?

- Death (*in 8 to 24 hours from perfectly well to dead*)
- Permanent brain damage
- Kidney failure
- Learning disability
- Hearing loss, blindness
- Limb damage (fingers, toes, arms, legs) that requires amputation
- Gangrene
- Coma
- Convulsions

CAN THE DISEASE BE TREATED?

- Antibiotic treatment, if received early, can save lives and chances of recovery are increased. However, permanent disability or death can still occur.
- Vaccinations are available and should be considered for:
  Those living in close quarters
  College students 25 years old or younger.
- Vaccinations are effective against 4 of the 5 most common bacterial types that cause 70% of the disease in the U.S. (but does not protect against all types of meningitis).
- Vaccinations take 7-10 days to become effective, with protection lasting 3-5 years.
- The cost of vaccine varies, so check with your health care provider.
- Vaccination is very safe – most common side effects are redness and minor pain at injection site for up to two days.
- Vaccination is available at your local community clinic/health center (List of local health departments can be found at dshs.texas.gov/immunize), Pharmacies (CVS, Walgreens, HEB, Walmart) or minute clinics.

HOW CAN I FIND OUT MORE INFORMATION?

•Contact your own health care provider.
•Contact your Student Health Nurse, Karen Puguan kxpuguan@baptisthealthsystem.com.
•Contact your local or regional Texas Department of Health office at dshs.texas.gov/immunize.
•Contact web sites: www.cdc.gov/ncidod/dbmd/diseaseinfo;
www.acha.org;https://dshs.texas.gov/IDCU/disease/meningitis/Meningitis.aspx

_____	_____
Student Name	Student Health Nurse
_____	_____
Student Signature	Student Health Nurse Signature
_____	_____
Date	Date