GEISINGER COLLEGE
OF HEALTH SCIENCES

Student Health Services RN Pre-Matriculation Requirements

Please have your Primary Care Physician (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

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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

_____

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

Pre- Matriculation Required Health Forms:

First Name | Middle Initial | Last Name

Date of Birth (MM/DD/YYYY) | Sex | Last 4 of SS#

Home Address

City | State | Zip

Cell Phone Number

Email Address | Emergency Contact (Name, Phone, Relationship)

STUDENT HEALTH SERVICES REQUIREMENTS

The following information is required ***prior to matriculation***.

NECESSARY LAB WORK (TITER) (REPORT *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 done)
   - All negative Quantitative Hepatitis B Surface Antibody results will require repeat of 2 or 3-dose Hepatitis B vaccine series and repeat **Quantitative** titer (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 twaibel@geisinger.edu***

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

1. MMR vaccine series – 2 doses of MMR
2. Varicella - documented vaccine series (2 doses) or varicella titer if you had chicken pox.
3. Meningococcal Conjugate vaccine dated ***AFTER*** 16th birthday.
4. Tdap Vaccination (within 10 years) or if >10 years, proof of prior Tdap and proof of current Td vaccine (within 10 years).
5. Hepatitis B vaccine (2-dose or 3-dose series)
6. Current flu vaccine (***Only required for January start***)

Also required is a Tuberculosis Screening (see next page):

1. **2-step PPD** (2 separate skin tests at least one week apart - 1st test within 3 months of matriculation or later) ***OR***
2. **Quantiferon Gold (IGRA) Blood Test** (dated within 3 months of matriculation or later – lab result must be provided)

GEISINGER COLLEGE
OF HEALTH SCIENCES

Student Requirement Tuberculosis Screening Form

Required: 2-step PPD (2 separate skin tests at least one week apart) or IGRA blood test (Quantiferon Gold) dated within 3 months of matriculation or later.

Name:_____**DOB:**_____

2-step PPD:

1st Placement Date*: _____ *Location:* _____*Right* _____ *Left

Placed by: _____

Reading Date*: _____ *Read by: _____

Result: _____mm induration _____Negative _____Positive

2nd Placement Date*: _____ *Location:* _____*Right* _____ *Left

Placed by: _____

Reading Date*: _____ *Read by: _____

Result: _____mm induration _____Negative _____Positive

Quantiferon Gold (IGRA):

Date: _____ _____Negative _____Positive

If Quantiferon Gold (IGRA) is done, a copy of lab report must be attached
A positive result of either the PPD or IGRA requires and attached copy of a negative chest x-ray report, dated *after* the positive result.

****Chest X-Ray (if required – if positive PCP follow-up is required):**

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.

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

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

If yes, please list: _____

_____

_____

Have you had the COVID-19 vaccine? _____ YES _____NO (if yes, please provide proof).

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)
Do you drink alcohol? _____ YES _____ NO
Do you have a history of substance abuse? _____ YES _____ NO
Do you currently utilize mental health or wellness services? _____ YES _____ NO
Geisinger Student Health Services has a full-time Behavioral Health Therapist at no charge.
Would you like to hear more about behavioral health services we offer? _____ YES _____NO

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