DePaul University
COLLEGE OF SCIENCE AND HEALTH
School of Nursing

DEPAUL UNIVERSITY SCHOOL OF NURSING

STUDENT PRE-ENTRANCE HEALTH FORM

This form is required for all DePaul School of Nursing students prior to the first day of the start of classes. Please contact the School of Nursing directly with any questions at nursing@depaul.edu.

SECTION 1: STUDENT INFORMATION			
First Name	***Middle Name***	***Last Name***	***Term Entering (i.e. Fall 2020)***
___/___/___	___ ___ ___ ___ ___ ___ ___		
Date of Birth	***DePaul Student ID#***	***E-mail Address***	

SECTION 2: IMMUNIZATIONS AND TITERS *(If you have received the appropriate vaccines, but have not yet had your titers drawn, it is advised to have your titers drawn at this visit.)*

MMR (Measles, Mumps, Rubella)

Dose 1: ___/___/___ Dose 2: ___/___/___ *Titer Date: ___/___/___

M D Y M D Y M D Y

Result: NEGATIVE / POSITIVE *(circle one)*

Varicella (Chicken Pox) ***History of disease is not acceptable documentation* Dose 1: ___/___/___ Dose 2: ___/___/___ *Titer Date: ___/___/___ M D Y M D Y M D Y Result: NEGATIVE / POSITIVE (circle one)
Hepatitis B Dose 1: ___/___/___ Dose 2: ___/___/___ Dose 3: ___/___/___ M D Y M D Y M D Y Titer Date: ___/___/___ Result: NEGATIVE / POSITIVE (circle one)
Tetanus/Diptheria/Pertussis (TDAP) - *Td and DtaP are not acceptable for this requirement. 1 TDAP dose administered within the last 10 years will meet this requirement.* Most recent dose: ___/___/___ M D Y
Influenza Vaccine - the vaccine must be from the current flu season Most recent dose: ___/___/___ M D Y
Tubuerculosis (TB) Test Test Completed: ___/___/___ Result: NEGATIVE / POSITIVE M D Y *(circle one)*

Test Type: QUANTIFERON GOLD / 2-STEP TUBERCULIN SKIN TEST (TST)

(circle one)

If a positive result is noted, a chest x-ray will be required. See below ONLY If you have had a positive blood test or skin test.

Date of Chest X-Ray: ___/___/___ *Date of Result:* ___/___/__ POSITIVE / NEGATIVE *(circle one)*

Have you ever received the BCG vaccination? YES / NO (circle one) Date Received: ___/___/___

Have you received treatment for tuberculosis due to a positive screening? YES / NO *(circle one)*

Treatment Start Date: ___/___/___ Treatment Stop Date: ___/___/___

Name of Medication:____

Healthcare provider verification - I verify to the best of my knowledge that the above immunization information is correct.

Provider Name (print or stamp)____

Provider's Phone #: - -

Provider's Signature:____

Date (mm/dd/yyyy): ______/______/_________

This form must be completed and returned with applicable attachments before the student is allowed to register and attend classes.

Please upload this completed form to your CastleBranch account upon completion.