



Dear MSN Students,

Prior to starting any clinical courses, you must complete the attached forms and return them to MSN Program Coordinator. These requirements include a completed health history, completed physical examination, current immunization record, current BCLS certification, proof of personal health insurance, and a criminal background check.

Please allow adequate time to complete these requirements and submit them in advance of your clinical experiences. If you have any questions, please contact Bobbi Towne, rtowne1@emich.edu or 734-487-2340.

Continued success in your program of study!

EASTERN MICHIGAN UNIVERSITY

SCHOOL of NURSING MSN Clinical Requirements

All admitted students must provide the following information to the School of Nursing, 311 Marshall Building. Scan/send to rtowne1@emich.edu or fax to 734-487-6946

Health Requirements:

1. A current health history (on form provided).
2. A current health examination (on form provided).
3. Complete immunization record (on form provided). **You must have received the vaccine or have a positive titer results.** *A history of the disease is not sufficient proof of immunity.* Without this proof, you will not be allowed to attend clinical courses.
4. Annual documentation of freedom from Tuberculosis is required (negative tuberculin skin test, current negative chest x-ray, or negative symptom checklist by a qualified healthcare provider).
5. A negative 7 panel urine drug screen is required. This can be obtained at Snow Health Center at a cost of \$40. You will be asked to sign a release for the School of Nursing. You can also have this done through your health care provider, Midwest Health etc.

Students may contact University Health Services at EMU for health examination, immunizations and tuberculosis testing at 743-487-1122, county health departments or personal health care provider.

Basic Life Support Certification:

You must provide proof of certification to provide adult, child, infant, two-person Cardiopulmonary Resuscitation (CPR) for the **Healthcare Provider** or **Professional Rescuer**. You can contact your local American Heart Association, American Red Cross or Snow Health Center (cost is \$60) for information on obtaining CPR certification. Make certain it is a course for health professionals, not lay persons.

Personal Health Insurance:

Proof of health insurance coverage is required. Students who do not have health insurance through their family or workplace can obtain health insurance through the university. EMU has an Accident and Sickness Plan provided through United Health Care Student Resources. The EMU insurance plan is not available for purchase until August and will not go into effect until September 1st. Information is available at Snow Health Center. Students who cannot afford this may contact the Public Health Department at 734-481-2000.

ALL STUDENTS ADMITTED TO THE NURSING PROGRAM MUST MEET THE REQUIREMENTS ABOVE

I have read, understand, and agree to the above EMU nursing student requirements. I have retained a personal copy of these requirements and related forms for my own use and student portfolio. Failure to complete these program requirements by the deadlines noted, will result in my not being able to attend nursing courses.

Student Signature

Printed Name

Date

Health Examination Form

TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT

Name _____
Last First Middle

Explain any significant family or personal history:

Height: _____ Weight: _____ Temp: _____ Pulse: _____ Resp: _____ BP: _____

Vision: Visual Acuity: Right 20/ _____ Left 20/ _____

Hearing: _____

Eye, Ear, Nose, Throat: _____

Neck, Thyroid: _____

Heart: _____

Lungs: _____

Abdomen, Hernia: _____

Nervous System: _____

Bone and Joint: _____

Skin: _____

Is student capable of regular physical activity? _____ If not, please explain.

Summary of findings: _____

Health Care Provider (Physician, Nurse Practitioner, Physician's Assistant), please sign and date:

Name: _____ Signature: _____
Please Print

Address: _____

Date: _____

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Immunization Record

****TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT****

Name: _____

Immunizations- Provide dates vaccines were given, or titer results. Students will be UNABLE to attend clinical courses without providing dates of vaccines or titer results. History of having had the disease is NOT sufficient proof of immunity.

Tdap Date Received: _____

Rubeola Date Received 1st Dose: _____ Second Dose: _____ (or) Titer Result: _____

Mumps Date Received 1st Dose: _____ Second Dose: _____ (or) Titer Result: _____

Rubella Date Received 1st Dose: _____ Second Dose: _____ (or) Titer Result: _____

***Rubella vaccine must be after 1969 or will need titer result as proof of immunity.**

Varicella Date Received 1st Dose: _____ Second Dose: _____ (or) Titer Result: _____

Hepatitis B Date Received 1st Dose: _____ Second Dose: _____ Third Dose: _____

***If student declines Hepatitis B. Vac. please document declination (below), and have student sign as well.**

Tuberculin Skin Test: Date: _____ Positive: _____ Negative _____

Chest X-Ray: Date: _____ Positive: _____ Negative _____

Symptom Checklist: Date: _____ Positive: _____ Negative _____

Urine Drug Screen (7 panel): Date: _____ Positive: _____ Negative _____

Health Care Provider (Physician, Nurse Practitioner, Physician's Assistant), please sign and date:

Name: _____ Signature: _____

Please Print

Student: Complete this bottom portion only if you are declining the Hepatitis B Vaccine

**DECLINATION FORM
Hepatitis B Vaccine**

I, _____, am fully aware of the risk of acquiring the Hepatitis B virus (HBV) as a result of possible exposure to contaminated blood or other infectious materials.

Nevertheless, I have decided not to receive the Hepatitis B injections that are recommended by Eastern Michigan University School of Nursing.

Student Signature/Print name

Date

EASTERN MICHIGAN UNIVERSITY

SCHOOL of NURSING

Health History Form

To be filled out by ***student:***

Name: Last _____ First _____ Middle _____

Address: Street _____ City _____

State _____ Zip _____

Enrollment for Semester Year: _____ **Student #** _____

Birth Date: _____

Person to be notified in case of emergency:

Name _____ Address _____

Relationship _____

Phone _____

Personal History:

Have you lived with or been in contact with anyone having Tuberculosis in the past two years? _____

If yes, please explain: _____

Do you have/have you ever had:

	Yes	No		Yes	No
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Persistent or Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety (treated with medication)	<input type="checkbox"/>	<input type="checkbox"/>
			Depression (treated with medication)	<input type="checkbox"/>	<input type="checkbox"/>
			Mental Illness (other)	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please explain:

Have you ever been hospitalized? Yes No If yes, for what and when?

Do you have any allergies? Yes No If so, specify: _____

Are you allergic to any drugs? Yes No If so, specify: _____

Do you have any physical impairment? Yes No If so, specify: _____

Students Signature: _____ **Date:** _____



Eastern Michigan University has partnered with Verified Credentials to manage your program requirements including the following:

- Background Report

To access Verified Credentials – Student go to:

<http://student.verifiedcredentials.com/?organization=easternmichigan>

How It Works:

1. **Enter code for the program you will be attending** located above the “Get Started!” button on the right side of the page

Nursing - MSN
WWCFT-92376

Nursing BS
TTCJG-82443

Post Baccalaureate Certificates
VWVKH-88649

RN/BS in Nursing Completion
VWVKD-98639

2. Create an account
3. Enter all required information
4. Provide supporting documentation
5. Track your progress
6. Information will automatically be shared with your school

If you have any questions, our Client Services Team is ready to assist you. Please call us at 800.938.6090 or email us at ClientServices@verifiedcredentials.com.