Policy # S-11

POLICY: PRE-ENTRANCE PHYSICAL EXAM

POLICY:
It is the Policy of the Nursing Program at the University of Pittsburgh at Titusville to require students seeking admission to the Nursing Program to submit documentation of a physical exam and documentation of specific immunizations for approval by the Admissions Committee. The University recognizes that certain fundamental physical and psychological requirements are essential for a person to perform all of the functions of a student nurse. These requirements are described in the Student Nurse Position Description, Policy #S-3. These same requirements are outlined in the Pre-Entrance Physical Examination Form that is attached to this Policy.

PROCEDURE:
1. Prospective students are required to obtain the Pre-Entrance Physical Examination Form from the Nursing Program office.

2. It is the responsibility of the prospective student to schedule an appointment with the medical physician of their choice to have the physical exam completed and the documentation completed in time for submission of this information to the Admissions Committee.

3. It is the student’s responsibility to pay for any and all costs associated with the physical examination and required immunizations.

4. All of the required immunizations must be completed before entrance into the nursing program with the exception of the Hepatitis series and the influenza vaccine. The Hepatitis series must be started prior to September 1st and the influenza vaccine must be obtained prior to October 31st. The remaining two Hepatitis vaccinations in the series may occur during the first year of the program.

5. The Nursing Program Pre-Entrance Physical Examination Form is required in addition to the University of Pittsburgh at Titusville Student Health Evaluation Form for several important reasons. The University Student Health Evaluation Form must be completed by the applicant. The Nursing Program Pre-Entrance Physical Examination Form must be completed by a licensed care provider. The Nursing Program’s Pre-Entrance Physical Examination Form checks for clearance according to specific behaviors (for example, the ability to carry 14-44 pounds) that student nurses are commonly expected to perform. The Nursing Program’s Pre-Entrance Physical Examination Form also identifies specific required immunizations that must be obtained to keep both students and clients safe while students are in the clinical areas.
**PRE-ENTRANCE PHYSICAL EXAMINATION FORM**  
*(must be completed by a licensed physician)*

Student’s Name ________________________________  Date __________________

The University recognizes that certain fundamental physical requirements are essential to perform all of the functions of a student nurse and that there are environmental factors inherent to the surrounding in which the student learns.

After performing a complete physical examination on the applicant, please indicate whether or not he/she can perform the following activities:

**PHYSICAL REQUIREMENTS**

<table>
<thead>
<tr>
<th></th>
<th>CAN PERFORM</th>
<th>CANNOT PERFORM</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Lifting 14-44 lbs.</td>
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<td>2.</td>
<td>Carrying 14-44 lbs.</td>
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<td>3.</td>
<td>Pushing/pulling 71-100 lbs.</td>
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<td>4.</td>
<td>Fine motor skills of all fingers and both hands.</td>
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<td>5.</td>
<td>Full manual dexterity of upper extremities.</td>
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<td>6.</td>
<td>Unrestricted movement of both lower extremities; neck, shoulders, back and hips.</td>
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<td>7.</td>
<td>Walking.</td>
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<td>8.</td>
<td>Standing 4-6 hours.</td>
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<td>9.</td>
<td>Sitting 2-4 hours.</td>
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<tr>
<td>10.</td>
<td>Twisting at waist.</td>
<td></td>
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<tr>
<td>11.</td>
<td>Kneeling</td>
<td></td>
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<td>12.</td>
<td>Climbing</td>
<td></td>
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<tr>
<td>13.</td>
<td>Squatting</td>
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</tbody>
</table>
14. Reaching above shoulders

15. Hearing WNL – aid permitted (must be able to function without lip reading)

16. Smelling WNL – (must be able to detect odors)

17. Touching (temperature and vibratory sense.)

18. Vision (color) must be able to distinguish shades of color.

19. Vision 20-20 with or without correction.

20. Depth perception WNL.

21. Speaks (clearly).

ENVIRONMENTAL FACTORS

<table>
<thead>
<tr>
<th>CAN PERFORM</th>
<th>CANNOT PERFORM</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Working closely with others.</td>
<td></td>
<td></td>
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<tr>
<td>2. Working around biohazards.</td>
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<tr>
<td>3. Working around infectious diseases.</td>
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<tr>
<td>4. Working with or near the deceased.</td>
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<tr>
<td>5. Working with hands in water.</td>
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</tbody>
</table>

Significant Medical History and Current Conditions: ____________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________
Current Medications: __________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Allergies: ___________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Free of communicable disease? _____ Yes _____ No
If no, please explain: __________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
Requirements:
1. MMR titer (some labs order them as: Rubeolla antibody IGG, Mumps antibody IGG and Rubella antibody IGG)
2. Varicella titer (Varicella antibody IGG)
3. PPD (Two step required) Information regarding testing included
4. Tetanus Booster (Tdap)
5. Hepatitis B Titer (a Hepatitis B Surface Antibody, Quantitative, must be drawn)
6. Annual Influenza vaccine in the Fall prior to October 31st. Please give documentation to secretary with date, type, lot #, and signature of provider.

**MUST BE COMPLETED BY THE PHYSICIAN/OR PHYSICIAN DESIGNATE**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>RESULTS</th>
<th>IMMUNE YES/NO</th>
<th>IMMUNIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Rubeola Titer (german measles)</td>
<td></td>
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<td>Attach results of MMR titer.</td>
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<tr>
<td>*Mumps Titer Screen</td>
<td></td>
<td></td>
<td>Attach results of MMR titer.</td>
</tr>
<tr>
<td>*Rubella Titer (measles)</td>
<td></td>
<td></td>
<td>Attach results of MMR titer.</td>
</tr>
<tr>
<td>Hepatitis B Titer</td>
<td></td>
<td></td>
<td>Attach results of Titer</td>
</tr>
<tr>
<td>Varicella Titer (chicken pox)</td>
<td></td>
<td></td>
<td>Attach results of varicella titer.</td>
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</tbody>
</table>

PPD (Two Step Required) Required Documentation for PPD

| 1. Date of PPD application and lot number of PPD vial | COMPLETE PPD DOCUMENT ON BACK | If a history of a positive PPD a chest x-ray is required within 3mo of admission and a copy of the report MUST be sent |
| 2. Date read with result | | |
| 3. RN’s initials who read result | | |

Tetanus Booster (Tdap) unless there is documented reaction to Pertussis, then only Td is required.

| Date: | Must be within 10 years from application date |

*or evidence of MMR Booster…if less expensive for client to have an MMR Booster, we will accept current MMR booster if it has been given within the last 5 years.
Please comment on the emotional stability of the student as it relates to his/her ability to perform, under stress, the essential functions of a student nurse.

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Physician Signature ____________________________ Date _______________________

Please return to: Patricia McClain, MSN, RN
Director Nursing Program
University of Pittsburgh at Titusville
504 E. Main Street, PO Box 287
Titusville, PA  16354
PPD ADMINISTRATION
Please complete the following:
(Step 1)

PRIMARY CARE: ______________________________________________________
Phone Number: ______________________________________________________

Patient’s Name: ______________________________________________________

Date Administered:_________ Date Read:_________
Interpretation: ________________ Size: ________________
Lot #:_______________________ Exp. Date: __________
Site: ___________ forearm

Administrator’s Signature:______________________________________________

PPD ADMINISTRATION
Please complete the following:
(Step 2)

PRIMARY CARE: ______________________________________________________
Phone Number: ______________________________________________________

Patient’s Name: ______________________________________________________

Date Administered:_________ Date Read:_________
Interpretation: ________________ Size: ________________
Lot #:_______________________ Exp. Date: __________
Site: ___________ forearm

Administrator’s Signature:______________________________________________