DUQUESNE UNIVERSITY

PRE-CLINICAL HEALTH REQUIREMENTS (PCHR) - RISING JUNIORS

- PCHR Guidelines and General Information

- All Health Requirements are due by ***July 15th.***

- All PCHR forms are available on the Duquesne University Health Service website.

- The Pre-Clinical Requirements Coordinator is located in Duquesne University Health Services (DUHS)
  Phone 412-396-1650
  Fax: 412-396-5655
  Email: pchr@duq.edu
  Address: Duquesne University Health Services (attn. Carol Dougher, RN)
  2nd Floor Union
  600 Forbes Avenue
  Pittsburgh PA, 15282-1920

- Duquesne University Health Services is able to provide:
  - Physical Examination $50.00
  - PPD (two-Step) $40.00
  - PPD (Annually) $20.00
  - Quantiferon Gold (Q-Gold) blood test –alternative to PPD- $90.00
  - Blood/Laboratory Testing for Immunity:
    - Available titers: Measles/Mumps/Rubella, Hepatitis B, Hepatitis C, Varicella (Chicken Pox)
- * Fees – Accepted forms of payment are cash, credit card or check payable to Duquesne University Health Service.
  *Fees are subject to change

- Duquesne University Center for Pharmacy Care
  - Immunizations can be obtained through the Duquesne University Center for Pharmacy Care. Appointments for immunizations can be scheduled by calling the center at 412-396-2155 or via email at cpc@duq.edu.
  - Duquesne University Center for Pharmacy Care are providers with most major medical insurance carriers including the Student Health Insurance Plan (SHIP).

- All PCHR documents must be submitted electronically to Health Services through the HEALTH SERVICE STUDENT PORTAL

- Health Service Portal Access:

  - Log into DORI
  - In the "Services and Information" box Select HEALTH SERVICE STUDENT PORTAL
  - Follow instructions in portal

DUQUESNE UNIVERSITY

Rising Junior
Pre-Clinical Health Requirements

All Health Requirements are due by July 15th.

Student's Name: _____

Phone:_____ Date of Birth: _____

TUBERCULOSIS SCREENING (must be done annually)

Use this form or attach a copy of the form of the facility where your PPD was given.

PPD (Mantoux) Test* Date Given: _____ (ALTERNATIVE: QUANTIFERON GOLD BLOOD TEST) PPD Date Read: _____ Induration (mm): _____ ❑Negative ❑Positive OR Q Gold results

Read by: (PRINT) _____Signature: _____

Name of Facility: _____ Phone Number: _____ **If**

POSITIVE (10 mm. or more induration/or positive result Q Gold) please evaluate as follows:

1. **Previous BCG Date:**_____
2. **Chest X-ray Date:** _____ Results:_____*(attach copy of x-ray report)*
3. **INH Prophylaxis** ❑ No ❑ Yes Dosage: _____ Duration:_____

Follow – up or questions may be directed to:

Allegheny County Health Department
Pulmonary Center
425 First Avenue, 1st Floor
Pittsburgh, PA 15219
(412) 578-8162

TETANUS

If your last Tetanus booster was over 10 years ago, repeat and send a copy with this form.

PHYSICAL EXAM

I have obtained a health history, performed a physical examination, and reviewed immunization status and laboratory results. In my estimation, this student has no physical, emotional, or mental limitations and is able to participate fully in student clinical activities in a health care or classroom setting.

(NOTE: ANY LIMITATIONS MUST BE DESCRIBED IN AN ATTACHMENT)

Examining Practitioner's Signature: _____ Date: _____

Examining Practitioner's Name: (PRINT)_____

Address: _____Telephone: _____

City: _____State: _____ Zip code:_____

INSTRUCTIONS

Once form is completed, all PCHR documents need to be submitted electronically to Health Services through the Health Service Student Portal - gain access by: (Log into DORI>under Service and Information tab>select "HEALTH SERVICE STUDENT PORTAL"
Follow instructions in portal

QUESTIONS ABOUT ITEMS ON HEALTH FORM

Contact: Pre-Clinical Health Requirements Coordinator (PCHR)
University Health Service
Phone: 412-396-1650
Fax: 412-396-5655
Email: pchr@duq.edu

Student should retain a copy of this completed form.

I give permission for information contained in this form to be shared with my individual school.

Student Signature_____Date: _____

DUQUESNE UNIVERSITY
SCHOOL OF NURSING

Annual Clinical Compliance

Seasonal Influenza Vaccine

Last name: _____ First name:_____ Middle initial: ____

Program: ☐ Basic BSN ☐ Second Degree BSN

Seasonal Influenza Vaccine (Must be completed by October 15th)

<table>
<tr><td colspan="4">Please complete and/or place sticker with information below</td></tr>
<tr><td colspan="2">Name of Vaccine: _____
Manufacturer:_____
Lot #_____</td><td colspan="2">Expiration Date: _____
NDC#_____
Date given: _____</td></tr>
<tr><td colspan="4">Health Care Provider Signature:</td></tr>
<tr><td>Address:</td><td>City:</td><td>State:</td><td>Zip:</td></tr>
<tr><td colspan="4">Phone number:</td></tr>
</table>

THIS FORM AND ALL SUPPORTING DOCUMENTS MUST BE UPLOADED TO DU HEALTH SERVICE STUDENT PORTAL
INSTRUCTIONS TO UPLOAD TO HEALTH SERVICE STUDENT PORTAL