PRE-CLINICAL HEALTH REQUIREMENTS (PCHR)-Rising Sophomores and Transfer Students

- **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
SCHOOL OF NURSING

Pre-Clinical Health Compliance #1 **MMR**
(Measles, Mumps, Rubella)

Last name: _____ First name:_____Middle initial: ____

Program: ☐ Basic BSN ☐ Second Degree BSN

MMR (Measles, Mumps, Rubella)	
Vaccination **#1** Date:	**Vaccination** **#2** Date:
REQUIRED BLOOD TESTS	
Please complete the following titers. ***Attach results*** *of laboratory tests.*	
Rubeola (Measles) titer results:	Date:
Mumps titer results:	Date:
Rubella (German Measles) titer results:	Date:
Negative or Equivocal results on any of the above REQUIRE an MMR Booster	
MMR Booster Dose/Date:	

I hereby attest to the validity of the above dates and testing results and certify them to be true and accurate:	
Examiner's Name (Print):	*Phone:*
Signature:	*Date:*

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Pre-Clinical Health Compliance #2

COVID-19 Vaccine,

Tetanus, Diphtheria, Pertussis Booster (Tdap),

and Meningitis Vaccination

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

Program: ☐ Basic BSN ☐ Second Degree BSN

COVID-19				
Covid-19: Please indicate which brand received. ◯ **Moderna** ◯**Pfizer** ◯**Johnson & Johnson** ◯_____ ◯**Exemption Request Submitted**	**Date:**	**Date:**	**Date:**	**Date:**

Tdap – Booster required within last 10 years	
Tetanus, Diptheria, Pertussis (Tdap):	Date of vaccination:

Meningococcal Vaccine(MCV4) must be on or after 16th birthday	
Meningococcal conjugate (MCV4)	Date of vaccination:

I hereby attest to the validity of the above dates and testing results and certify them to be true and accurate:	
Examiner's Name (Print):	*Phone:*
Signature:	*Date:*

DUQUESNE UNIVERSITY
SCHOOL OF NURSING

Pre-Clinical Health Compliance #3

Hepatitis B Series

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

Program: ☐ Basic BSN ☐ Second Degree BSN

Hepatitis B Vaccine - Required		
Vaccination **#1** Date:	**Vaccination** **#2** Date:	**Vaccination** **#3** Date:
A positive Hepatitis B surface antibody titer is required following 3 dose series. (Either HepBsAb or antiHepB)		
Titer Results: ***Attach results*** *of laboratory tests.*	Date:	
If titer is negative, must complete HEPATITIS B dose # 1 then REPEAT Titer. If REPEAT titer is Negative, Doses # 2 and #3 are required with a final REPEAT titer.		
Vaccination provided following NEGATIVE **titer** 1st Dose Date:		
Repeat titer date and results: (If negative, Doses #2 and 3 required)		
2nd Dose Date:	3rd Dose Date:	
Repeat Titer date and results:		

I hereby attest to the validity of the above dates and testing results and certify them to be true and accurate:	
Examiner's Name (Print):	*Phone:*
Signature:	*Date:*

DUQUESNE UNIVERSITY
SCHOOL OF NURSING

Pre-Clinical Health Compliance #4 **Varicella Vaccine**

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

Program: ☐ Basic BSN ☐ Second Degree BSN

Varicella Vaccine (Chicken Pox)	
Vaccination **#1** Date:	**Vaccination** **#2** Date:
OR	
If history of disease, Varicella IgG titer required. ***Attach results*** *of laboratory tests.* If positive titer, no vaccination is required as immunity has been verified.	
Titer Results:	**Date:**
Negative titer results REQUIRE two doses of vaccine.	

I hereby attest to the validity of the above dates and testing results and certify them to be true and accurate:	
Examiner's Name (Print):	*Phone:*
Signature:	*Date:*

DUQUESNE UNIVERSITY
SCHOOL OF NURSING

Pre-Clinical Health Compliance #5

Tuberculosis Testing – 2-Step

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

Program: ☐ Basic BSN ☐ Second Degree BSN

Testing must start on or after April 15th

MANDATORY 2-STEP TUBERCULOSIS SKIN TEST "PPD"

PPD (2^{nd} step within 10-21 days of first)	Date given:	Date read: (48-72 hours after placement)	Results: (>10mm induration = positive) Induration in mm	NEGATIVE Result	POSITIVE Result**
STEP #1					
STEP #2					

OR either of following blood tests may replace the 2-step PPD

Select One: ☐ **Interferon Gamma Release Assay (IGRA)** ☐ **T-Spot/Quantiferon Gold**	Date obtained:	Negative	Positive**

** POSITIVE RESULTS

(PPD > 10 mm OR Positive IGRA or T-Spot Test)

Chest Xray REQUIRED Copy of x-ray must be attached	**Date:**	**Result:**
INH Treatment:	**Date Started**	**Date Completed**

I hereby attest to the validity of the above dates and testing results and certify them to be true and accurate:	
Examiner's Name (Print):	*Phone:*
Signature:	*Date:*

DUQUESNE UNIVERSITY
SCHOOL OF NURSING

Pre-Clinical Health Compliance #6

Physical Examination and Student Statement

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

Program: ☐ Basic BSN ☐ Second Degree BSN

TO BE COMPLETED BY HEALTH CARE EXAMINER	
Physical exam completed on (date) _____ for the above named individual	
I have obtained and reviewed a health history for this individual, and have reviewed immunization status and laboratory results. I certify that this student has no physical limitations and is able to fully participate in nursing class and clinical practice. ***Note:*** *ANY LIMITATIONS OR EXCLUSIONS MUST BE DESCRIBED IN AN ATTACHMENT*	
Examiner's Name (Print):	
License #:	*Phone:*
Signature:	*Date:*

STUDENT STATEMENT (TO BE COMPLETED BY STUDENT)

The information provided on the above forms is correct. Attached are copies of all required information and results. I understand that failure to complete this information may jeopardize my progression in the nursing program. *I give permission for information contained in this form to be shared with faculty/staff of the School Of Nursing. I authorize release of this information, upon request, to any organization providing a clinical rotation in which I participate. I forever release & discharge Duquesne University, their respective employees and agents from any claims, damages losses, liabilities, and expenses arising out of gathering & reporting this information. THE FOLLOWING FORMS HAVE BEEN COMPLETED IN THEIR ENTIRETY AND HAVE BEEN/ARE BEING SUBMITTED:*

Form #1: ☐*MMR Form*
Form #2: ☐ *Tdap / Meningitis Vaccine Form*
Form #3: ☐ *Hepatitis B*
Form #4: ☐ *Varicella*
Form #5: ☐ *TB Form*
Form #6: ☐ *Physical Exam Form and Student Statement*

Student Signature:	*Date:*

DUQUESNE UNIVERSITY
SCHOOL OF NURSING

Pre-Clinical Health Compliance #7

Annual Seasonal Influenza Vaccine

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

Program: ☐ Basic BSN ☐ Second Degree BSN

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

Please complete and/or place sticker with information below			
Name of Vaccine: _____ Manufacturer:_____ Lot #_____	Expiration Date: _____ NDC#_____ Date given: _____		
Health Care Provider Signature:			
Address:	City:	State:	Zip:
Phone number:			

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