

- ❖ **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](mailto:pchr@duq.edu)
  - Address: Duquesne University Health Services (attn. Carol Dougher, RN)  
2<sup>nd</sup> 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](mailto: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**



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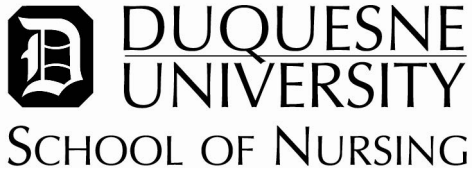
Pre-Clinical Health Compliance #1 **MMR**  
**(Measles, Mumps, Rubella)**

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_

Program:  Basic BSN       Second Degree BSN

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

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



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.				
<input type="radio"/> Moderna	<input type="radio"/> Pfizer	<input type="radio"/> Johnson & Johnson	<input type="radio"/> _____	
<input type="radio"/> Exemption Request Submitted				

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

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

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



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Pre-Clinical Health Compliance #3

**Hepatitis B Series**

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_

Program:  Basic BSN  Second Degree BSN

<b>Hepatitis B Vaccine - Required</b>		
<b>Vaccination #1</b> Date:	<b>Vaccination #2</b> Date:	<b>Vaccination #3</b> Date:
A positive Hepatitis B surface antibody titer is required following 3 dose series. (Either HepBsAb or antiHepB)		
Titer Results: <b><i>Attach results of laboratory tests.</i></b>		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.		
<b>Vaccination provided following NEGATIVE titer</b> 1 <sup>st</sup> Dose Date:		
<b>Repeat titer date and results:</b> (If negative, Doses #2 and 3 required)		
2 <sup>nd</sup> Dose Date:		3 <sup>rd</sup> Dose Date:
<b>Repeat Titer date and results:</b>		

*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 #4 **Varicella Vaccine**

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_

Program:  Basic BSN  Second Degree BSN

<b>Varicella Vaccine (Chicken Pox)</b>	
<b>Vaccination #1 Date:</b>	<b>Vaccination #2 Date:</b>
<b>OR</b>	
<b>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.</b>	
<b>Titer Results:</b>	<b>Date:</b>
Negative titer results REQUIRE two doses of vaccine.	

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



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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 <sup>nd</sup> 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**
<b>STEP #1</b>					
<b>STEP #2</b>					

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

Select One:	Date obtained:	Negative	Positive**
<input type="checkbox"/> Interferon Gamma Release Assay (IGRA) <input type="checkbox"/> T-Spot/Quantiferon Gold			

**\*\* POSITIVE RESULTS**

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

<b>Chest Xray REQUIRED</b> Copy of x-ray must be attached	<b>Date:</b>	<b>Result:</b>
<b>INH Treatment:</b>	<b>Date Started</b>	<b>Date Completed</b>

*I hereby attest to the validity of the above dates and testing results and certify them to be true and accurate:*

<i>Examiner's Name (Print):</i>	<i>Phone:</i>
<i>Signature:</i>	<i>Date:</i>



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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

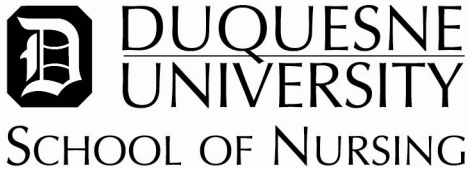
Form #4:  Varicella

Form #5:  TB Form

Form #6:  Physical Exam Form and Student Statement

Student Signature:

Date:



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 15<sup>th</sup>)**

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

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