

STUDENT INSTRUCTIONS FOR BELLARMINE UNIVERSITY ACCELERATED SECOND-DEGREE NURSING

About CertifiedProfile

CertifiedProfile is a secure platform that allows you to order your background check & document tracking online. Once you have placed your order, you may use your login to access additional features of CertifiedProfile, including document storage, portfolio builders and reference tools. CertifiedProfile also allows you to upload any additional documents required by your school.

Order Summary

Required Personal Information

In addition to entering your full name and date of birth, you will be asked for your Social Security Number, current
address, phone number and e-mail address.

> Immunizations

 Document trackers provide secure online storage for all of your important documents. At the end of the online order process you will be prompted to upload specific documents required by your school for immunization, medical or certification records.

Payment Information

At the end of the online order process, you will be prompted to enter your Visa or Mastercard information. Money
orders are also accepted but will result in a \$10 fee and an additional turn-around-time.

Place Your Order

Go to: www.CertifiedBackground.com and enter package code:

BC95 – Background Check & Immunizations \$65

You must renew your Medical Document Manager annually. You will be notified by CertifiedBackground when it's time to renew. There is a \$20 annual fee.

You will then be directed to set up your CertifiedProfile account.

View Your Results

Your results will be posted directly to your CertifiedProfile account. You will be notified if there is any missing information needed in order to process your order. Although 95% of background check results are completed within 3-5 business days, some results may take longer. Your order will show as "In Process" until it has been completed in its entirety. Your school's administrator can also securely view your results online with their unique username and password.

Immunization Requirements

ALL health requirements are due by March 15, 2014 EXCEPT TB testing which is due by May 2, 2014

Measles, Mumps & Rubella (MMR)

- -There must be documentation of one of the following:
 - 2 vaccinations
 - Positive antibody titers for all 3 components (lab reports required)

Varicella (Chicken Pox)

- -There must be documentation of one of the following:
 - 2 vaccinations
 - Positive antibody titer (lab report required)
 - Medically documented history of disease

Hepatitis B

- -There must be documentation of one of the following:
 - 3 vaccinations
 - Positive antibody titer (lab report required)
 - Declination waiver(available in your school handbook)

TB Skin Test

- -There must be documentation of one of the following: No later than May 10th
 - 2 step TB Skin test (1-3 weeks apart) must be submitted on the Bellarmine University Mantoux TB Skin Test Form after both results are recorded.
 - If positive results, provide a clear Chest X-Ray (lab report required OR physician verification of titer results required)
 - Testing must be completed between April 15-May 2, 2014. Results must be uploaded to Certified Background by May 2, 2014.

Tetanus, Diphtheria & Pertussis (Tdap)

-There must be documentation of a Tdap booster within the past 10 years OR a Td booster within the past 2 years.

CPR Certification

-Must be the American Heart Association Healthcare Provider course. Copy must be front and back of the card, card must be signed. Card must not expire between May 2014 and May 2015.

Physical Examination

-Provide your physical exam form completed and signed by a medical professional. Physical exam form can be found in your school handbook.

CNA Course Completion

-Provide certificate of completion of a Medicaid approved Certified Nurse Aide (CNA) course.

I NEED HELP!!!

If you need assistance please contact CertifiedProfile at 888-666-7788 or studentservices@certifiedprofile.com and a Student Support Representative will be available Monday-Thursday 8am-8pm, Friday 8am-6pm & Sunday 10am-6:30pm EST.





BELLARMINE UNIVERSITY LANSING SCHOOL OF NURSING AND HEALTH SCIENCES

HEALTH RECORD

PART I Health History

To be completed by the nursing faculty member/student nurse.

Biographical Information Name: Program: DBSN DMSN DDNP □Clinical faculty Birth Date: Address (local): (permanent): Telephone (local): _____ (permanent): _____ Telephone (cell): _____ EMAIL address: _____ Notify in Emergency: Relationship: Address: Telephone: _____ Physician/ Nurse Practitioner: Address: _____ Telephone: _____ Health Insurance Company: _____ Identification Number: _____ Group Number: _____ Present and Past Health Status B. Allergies: Medications: Prescriptions: Over-the-Counter: Previous Surgeries: Chronic Illness/ Problems: Limitations on Activities:

Indicate the year in which the following experienced or were diagnosed: Asthma: Hepatitis: Cancer: Mononucleosis: Diabetes: Lung Disorders: Epilepsy: Muscular Disorders: Emotional Disorders: Rheumatic Fever: Skeletal/Joint Disorders: Heart Disorders: Headaches: _____ Visual Disorders: Hearing Disorders: _____ Other: ☐ I attest that the information in this Student/Faculty Health Record is accurate to the best of my knowledge. ☐ I understand that I will not be admitted to the clinical experiences if the health record is incomplete, outdated, and/ or all immunizations/health screenings are not properly documented as specified in the BSN Student Handbook. ☐ I must be able to meet the basic technical standards of performance necessary for the practice of nursing for progression in the program of study. Signature of Nursing Student/Faculty: Date of signature Planned start date for clinicals

Form revised 03/2013

*** CONFIDENTIAL INFORMATION ***

Part II

PHYSICAL EXAMINATION FORM

(To be completed by a primary healthcare provider (APRN, MD, PA.)

Patient name	DOB		
Start date for clinicals (mo	onth/yr)		
Date of physical exam			
Vital Signs Ht: Wt: Tem	np.: Pulse:	Resp.: B/P:	
	NORMAL	ABNORMAL	
Skin/ Hair/ Nails Head Ears/ Nose/ Throat Neck Chest and Lungs Heart and Peripheral Vascular Breasts Abdomen Musculoskeletal Neurological Is there any health condition to program? Yes [] No [] F	hat would hinder please describe an	progress through a nursing	etai
(Print) Examiner's Name		Date of Examination	
Examiner's Signature		Examiner's Title	
Address:			
Telephone:			

IMMUNIZATION CERTIFICATE

(Required of each individual who is enrolled or works in clinical facilities as a representative of Lansing School of Nursing and Health Sciences. Documentation must be on this form; copies of medical records and older immunization certificates will NOT be accepted)

Individual(First)	(Middle)	(Last)
• •		,,
Birth dateBellan	Cilnical start date	
Name and Address of Emergency (Contact:	
•	• • • • • • • • • • • • • • • • • • • •	(Zip Code)
CERTIFY THAT THE ABOVE NAMED I	PERSON HAS RECEIVED MIMUNIZ	ATIONS AS NOTED BELOW.
Signature of Physician, Health Car	e Provider, or Health Departme	nt designee:
		Date
Print Name of Physician, Health Ca	•	•
ADDRESS		PHONE #
immunization	Date Administered (00/00)	Comments
Tetanus, diphtheria, pertussis (Td/TDaP)		Next booster due date
Substitute one time dose TDap for Td booster, then boost with Td	TDaP	
every 10 yrs.		
Measles, mumps, rubella (MMR)		Titer date and results (include copy of lab report)
2 doses of vaccine required	#1	Measies
OR Laboratory evidence of immunity	e2	Mumps
(titers) to all 3 diseases		Rubella
Varicella (Chicken Pox) 2 doses of single antigen varicella	#	HCP Confirmation Month/year of disease
vaccine OR	« <u> </u>	Titler date and results
Laboratory evidence of immunity (titer OR	1	Lifet date and leading
HCP diagnosis/verification of varicets or herpes zoster		
Hepatitis B	81	
CDC recommends that health care personnel receive 3 doses of Hep B	**************************************	
vaccine; Student/faculty must sign waiver if not completing the Hep B		
Series	#5	
Other vaccinations		

Form Revised 10/11. For further information, consult CDC Adult immunization Schedule at http://www.cdc.gov/vaccines/recs/schedules/adult-schedule.htm#print.

BELLARMINE UNIVERSITY MANTOUX TUBERCULIN SKIN TEST CERTIFICATE

NAME		DOB	Student ID #
Last	First		
STEPANENCE SERVICES	N. STATISTICS		
Manufacturer		Menufacturer	The state of the s
Lot #/ Exp date .	•	Lot #/ Exp date	
Dose	0.1 mL	Dose	0.1 mL
Sthe		Site	
Date admin (mo/day/yr)		Date admin (mo/day/	YF)
Time admin		Time admin	
Administered by		Administered by	
		2	
Time read		Time reed	
Date reed		Date reed	
Results in mm		Results in mm	
Reed by		Read by -	
FOLLOW-UP RECOMN	MENDED	□YES □NO	
EVALUATOR'S SIGNATURE	;	DATE	
EANTON: OU 3 200 UNIONE	(RN, APRN, PA, MD)		
		ONLY IF FOLLOW-UP IS RECOMM	VENDED
	COMPLETE THIS SECTION	OREA IN POLECULAR OF IS RECOMM	weight to
REASON FOR FOLLOW	V-UP		
IF SERVICE FOR ISSUES W	Design Burgary		
DATE of LAB TEST			
INTERPRETATION	OMEGATIVE	The state of the s	
IP CHEST X RAY IS INCH	enter de la constant	Jack Michille Box 1	
DATE of CKR	PARAMETAL		
INTERPRETATION	CHORMAL	CABNORMAL COONSISTENT WITH	SECTION OF SECTION SEC
CHRONIC COUGH GREATER T	THAN SWEEKS	and the second	
PRODUCTION OF SPUTUM (NLOOD-STREAKED)		
UNEXPLAINED WEIGHT LOSS			
FEVER			
FATIGUE			
NIGHT SWEATS		_	
SHORTNESS OF BREATH			
	CONSIDERED FREE OF TUBER	CULOSIS IN A COMMUNICABLE FORM	
EVALUATOR'S SIGNATUR	E	URIC	