



Standard Health Care Services Inc. College of Nursing
7600 Leesburg Pike, 200 East Falls Church VA 22043
Telephone: (703) 891-1787 Fax: (703)891-1789
www.standardcollege.edu

Student Name: _____ DOB: _____

CHECKLIST FOR RE-ENROLLED STUDENTS

- Signed Disclosure Forms - Due Date: _____
- Health Requirements Form – Due Date: _____
 - Physical Examination Form
 - Immunization Form
 - Questionnaire for Tuberculosis
 - CPR (American Heart Association, health care provider card)
 - Covid Vaccine Card
- Verifystudents.com - Due Date: _____
 - Criminal Background Check
 - Drug Test



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info@standardcollege.edu

HEALTH HISTORY AND PHYSICAL FOR NURSING PROGRAM

This form must be filled out by applicant and a licensed primary care provider: physician, physician's assistant, nurse practitioner. Physical examinations must be completed no sooner than 3 months prior to entering the program.

PART I Personal Information to be completed by the STUDENT- PLEASE PRINT.

Last Name:	First Name:	Date Of Birth:
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	E-Mail:

To the best of my knowledge, I do not have a physical or mental condition that would prevent me from performing the essential requirements of the applicable Nursing Program. I hereby authorize the release of my medical information to clinical affiliates after my admission and prior to being assigned to a clinical rotation. I understand that I may be dismissed from the program if I knowingly submit false information.

Student Signature: _____ Date: _____

PART II Physical assessment — to be completed by a HEALTHCARE PROVIDER

Height(in):	Weight (lbs):	ANY IRREGULARITIES OF THE FOLLOWING?				
B/P:	T:	YES	NO		YES	NO
HGB (or HCT):	Urinalysis:	Head		Cardiovascular system		
Sugar: Alb:	Micro:	Ears		Abdomen		
Vision: OD:	OS:	Nose:		GI system		
Corrected? Yes <input type="checkbox"/> No <input type="checkbox"/>		Throat		GU system		
General Appearance:		Neck		CNS/Reflexes		
		Breasts		Back		
		Chest		Extremities		
Describe any conditions currently being treated:		Please Explain any YES answers:				

Allergies: _____

PART III Essential Functions for Students - to be completed by a HEALTHCARE PROVIDER

Students entering the program must be able to perform all of the following essential functions and standards to become a licensed nurse.

Yes	No	
		1. Communication: Establish interpersonal rapport and communicate in English, both verbally and in writing with clients, physicians, peers, family members and the health care team from a variety of social, emotional, cultural and intellectual backgrounds.
		2. Mobility: Physical abilities sufficient to move from room to room and maneuver in small spaces and administer cardio-pulmonary procedures.
		3. Motor Skills: Gross and fine motor abilities sufficient to provide safe and effective nursing care in order to calibrate and use equipment; position patients/clients.
		4. Hearing; Auditory ability sufficient to monitor and assess health needs in order to hear monitor alarms, emergency signals, auscultatory sounds, and cries for help.
		5. Visual: Visual ability sufficient for observation and assessment necessary in nursing care in order to observe patient/client responses.
		6. Tactile: Tactile (touch) ability sufficient for physical assessment and/or those functions related to therapeutic interventions.

The student has the Physical and Emotional Health to complete the requirements of the nursing program.

Yes No

Are there any other essential functions that you believe the student may lack that would interfere with their ability to become a licensed nurse? Yes No

Student Name: _____ DOB: _____

PART IV Required Immunizations — to be completed by a HEALTHCARE PROVIDER

The following immunizations are required. It is the student's responsibility to see that the completed form is submitted to Standard College prior to clinical assignment.

REQUIRED IMMUNIZATIONS	NOTE: To achieve compliance ensure ALL vaccines are completed.
<p>MMR Vaccine (Rubella, Rubeola, Mumps) The student must have proof of MMR vaccination or documented proof of immunity shown by mumps, rubeola, and rubella titers.</p>	<p><u>Measles, Mumps, Rubella (MMR) Vaccines:</u> Date of injection: ____/____/____ (1) Date of injection: ____/____/____ (2) OR Blood Test Titer of: <input type="checkbox"/> Positive Mumps titer: Date: ____/____/____ <input type="checkbox"/> Positive Rubeola titer: Date: ____/____/____ <input type="checkbox"/> Positive Rubella titer: Date: ____/____/____</p>
<p>Varicella Vaccine (Chickenpox) The student must have proof of Varicella vaccination or documented proof of immunity shown by varicella titers.</p>	<p><u>Varicella (Chickenpox) Vaccines:</u> Date of injection: ____/____/____ (1) Date of injection: ____/____/____ (2) OR Blood Test Titer of: <input type="checkbox"/> Positive Varicella titer: Date: ____/____/____</p>
<p>Tdap Vaccine The student must have proof of Tdap Vaccine (Tetanus/Diphtheria WITH Pertussis). Booster needed every 10 years. (Please note: The requirement is Tdap and not Td or Dtap)</p>	<p><u>Tdap Vaccine:</u> Date of injection: ____/____/____</p>
<p>Hepatitis B Vaccine The student must have proof Hepatitis B Vaccine (3 dose series) OR Heplisav-B (2 dose series) or documented proof of immunity shown by Positive Hepatitis B IgG antibody Titer.</p>	<p><u>Hepatitis B Vaccine:</u> Date of injection: ____/____/____ (1) Date of injection: ____/____/____ (2) Date of injection: ____/____/____ (3) OR Blood Test Titer of: <input type="checkbox"/> Positive Hepatitis B titer: Date: ____/____/____</p>
<p>Influenza Vaccine Influenza (inactivated virus) Vaccine. Annual single dose required during Flu Season.</p>	<p><u>Flu Vaccine:</u> Date of injection: ____/____/____</p>
<p>COVID-19 Vaccine The student must have documented proof of COVID19 vaccination. Vaccine must be FDA or WHO-Approved. If you received an international vaccine, it must be a World Health Organization approved vaccine.</p>	<p><input type="checkbox"/> <u>Pfizer (2) dose vaccine:</u> <input type="checkbox"/> <u>Moderna (2) dose vaccine</u> <input type="checkbox"/> <u>Johnson & Johnson/Janssen (1) dose vaccine</u> <input type="checkbox"/> <u>WHO Approved COVID-19 (2) dose vaccine</u> - Name of Vaccine: _____ Date of injection: ____/____/____ (1) Date of injection: ____/____/____ (2) <input type="checkbox"/> <u>COVID-19 Booster vaccine</u> - Name of Vaccine: _____ Date of injection: ____/____/____ (1)</p>
<p>Tuberculosis Students MUST undergo Tuberculin skin test (TST) OR have a TB Screening Blood Test - INTERFERON-GAMMA RELEASE ASSAY (IGRA) - Quantiferon or T-Spot. All testing must be dated less than 3 months from the first day of classes. Chest X-Ray - If patient has a documented history of a positive TB test, a chest x-ray report must be submitted with this form. Chest X-Ray must be dated within ONE (1) year from the first day of classes. Treatment for TB or LTBI - Documentation of treatment must be submitted with form</p>	<p><input type="checkbox"/> <u>Tuberculin Skin Test:</u> Date Placed: ____/____/____ Date read: ____/____/____ Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> <u>Quantiferon or T-Spot</u> Date Test Given: ____/____/____ Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> <u>Chest X-Ray:</u> Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive Date read: ____/____/____ <input type="checkbox"/> <u>Treatment for TB or LTBI</u> Date treatment started: ____/____/____ Date treatment completed: ____/____/____ Name of medication: _____</p>

HEALTH CARE PROVIDER INFORMATION AND SIGNATURE: (must have all information)

Printed Name and Title: _____

Name of Practice or Clinic: _____

Address: _____

Office Phone Number: _____ **Official Stamp (if available):** _____

Health Professional's Signature: _____ **Date:** _____



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TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

STUDENT NAME: _____ Birth Date: ____/____/____

ADDRESS: _____

HOME PHONE _____ CELL PHONE: _____

SSN#: _____ E-MAIL: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Have you ever:

Had active TB	Yes	No
Taken medication for TB exposure	Yes	No
Had a reaction to TB skin test	Yes	No
Been told you had a weakened immune system	Yes	No

Do you CURRENTLY have any of the following?

Persistent cough	Yes	No
Night sweats	Yes	No
Unexplained weight loss	Yes	No
Unexplained tiredness	Yes	No
Persistent fever	Yes	No
Hoarseness	Yes	No

Have you ever received BCG vaccination?	Yes	No
Were you born in the USA?	Yes	No

If no, what is your country of origin? _____

Since your last TB skin test or TB questionnaire:

Have you had exposure to anyone with known TB disease?	Yes	No
Have you had and abnormal chest x-ray?	Yes	No

When was your first positive TB skin test? _____

When was your most recent chest x-ray? _____

Was your most recent chest x-ray normal? _____

Explain any yes answers:

I certify that the information I have provided is complete and true to the best of my knowledge.

Signed: _____ Date: _____

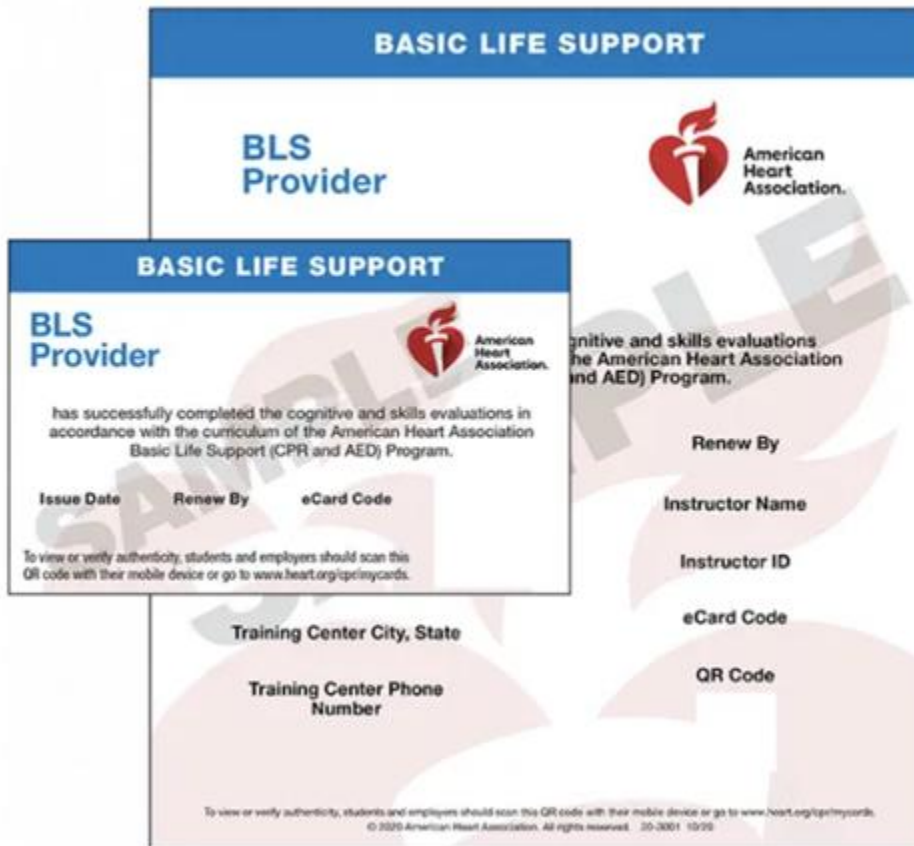


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Basic Life Support (BLS) Healthcare Professional CPR Card

Standard College only accepts CPR classes that have been certified by the American Heart Association (AHA).

You CPR card should look like the picture below:



If you do not have a BLS Healthcare Provider CPR Card, you may find a **BLS Provider** course in the following link.

https://ahainstructornetwork.americanheart.org/AHA/ECC/classConnector.jsp?pid=ahaecc.classconnector.home&courseid=1-5BPOMK&coursestyle=classroom&language=1001&_ga=2.116153348.36359595.1625768639-206876870.1625768639

Standard College does not offer CPR courses.



COLLEGE OF NURSING

Standard Healthcare Services Inc. – Practical Nursing Program

Background Check & Drug Test Instructions

Before Starting:

- A valid email is **REQUIRED**
(if you do not have an email account you can establish a free account at Yahoo.com)
- Have your credit card (Visa/MasterCard/American Express/Discover) information ready in order to process payment. Your credit card will be charged **\$76.00** for the service.

NOTE: You may incur additional fees if you have an address from the State of NY

Getting Started:

1. Log onto our website at <https://fadv.com/verifystudents> and click Start Here
2. Use this special promotional code: **SHSPNBGDT**
3. Complete profile & e-sign forms as they appear

After completing online process:

1. Drug testing: go to collection site listed on ePassport
 - Bring authorization form & government photo ID, e.g. – driver's license

PLEASE NOTE THE DRUG SCREEN MUST BE COMPLETED
BY **3/1/2014 6:00:00 PM PST**

Authorization Form
REGISTRATION NUMBER: 112489992

Order Expiration Date/Time: 3/1/2014 6:00:00 PM PST Authorization Barcode #: 112489992

Employer/Contractor Information:	Medical Review Officer/Managed Service Provider:
CORPORATE SERVICES 8523 HOUSE 1450 COVINGTON STREET CLEVELAND, OH 44130 Phone: 313-241-6577 ext. 000-000-000	DR. CHARLES J. COOPERFIELD MEDICAL REVIEW OFFICE 1122 S WICKHAM ROAD SUITE 104 WILMINGTON, DE 19804 Phone: 302-822-2352

Test Information	Test Details
Order Information Order: Test name ID: *****1133 Work Phone: 888.227.9282 Work Phone: 888.888.8882	Exam Site Test Pre-Registration Account: 000000

Service(s) to be Performed	Laboratory	Laboratory Test
Service: 10/Pass/0/00	Laboratory: LabCorp	Laboratory Test: 481830001

Collection Site Information
LABCORP
1303 BARTHOLOME BLVD, SUITE 230
BARTHOLOME, CA 94920
Phone #: 415-475-3120

Please bring your government issued photo-ID for identification at the collection facility.
You must bring this authorization form to the collection facility.

NOTE: A unique login will be emailed to you. This will allow you to log back into <https://fadv.com/verifystudents> and retrieve a copy of your report.

Please note that this information is for the sole purpose of background screening for this school only. Unauthorized use of our service is prohibited

Standard Healthcare

**American
Discount
Uniform
inc**

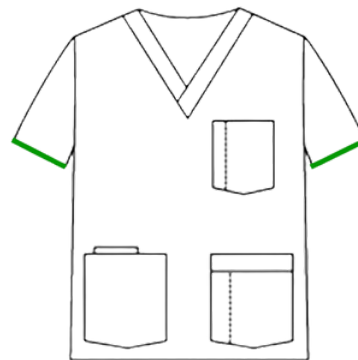

**Required
Uniforms**



Mix + Match to create your style!



**Tops + Jackets
come with
school emblem.**



All tops come with green trim on the collar and sleeves.

Order Online Now!

americandiscountuniform.com

Group Code: STANDN