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 RE Enrollment Agreement (Contract)

☐ Signed Disclosure Forms

☐ Health Requirements Form
- ☐ Physical Examination Form
- ☐ Immunization Form
- ☐ Questionnaire for Tuberculosis
- ☐ CPR (American Heart Association, health care provider card)
- ☐ Covid Vaccine Card

☐ Verifystudents.com
- ☐ Criminal Background Check
- ☐ Drug Test

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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):
B/P:	T:
HGB (or HCT):	Urinalysis:
Sugar: Alb:	Micro:
Vision: OD:	OS:
Corrected? Yes No	
General Appearance:	

ANY IRREGULARITIES OF THE FOLLOWING?

	YES	NO		YES	NO
Head			Cardiovascular system		
Ears			Abdomen		
Nose:			GI system		
Throat			GU system		
Neck			CNS/Reflexes		
Breasts			Back		
Chest			Extremities		
Please Explain any YES answers:					

Describe any conditions currently being treated:

_____

Allergies: _____

Has the student ever been under observation for any severe physical or emotional disease or drug problem?
IF so, EXPLAIN: _____

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, ausculatory 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.

Are there any other essential functions that you believe the program applicant 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.**
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.	Measles, Mumps, Rubella (MMR) Vaccines: Date of injection: _____/_____/_____ (1) Date of injection: _____/_____/_____ (2) OR Blood Test Titer of: ☐ Positive Mumps titer: Date: _____/_____/_____ ☐ Positive Rubeola titer: Date: _____/_____/_____ ☐ Positive Rubella titer: Date: _____/_____/_____
Varicella Vaccine (Chickenpox) The student must have proof of Varicella vaccination or documented proof of immunity shown by varicella titers.	Varicella (Chickenpox) Vaccines: Date of injection: _____/_____/_____ (1) Date of injection: _____/_____/_____ (2) OR Blood Test Titer of: ☐ Positive Varicella titer: Date: _____/_____/_____
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)	Tdap Vaccine: Date of injection: _____/_____/_____
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.	Hepatitis B Vaccine: Date of injection: _____/_____/_____ (1) Date of injection: _____/_____/_____ (2) Date of injection: _____/_____/_____ (3) OR Blood Test Titer of: ☐ Positive Hepatitis B titer: Date: _____/_____/_____
Influenza Vaccine Influenza (inactivated virus) Vaccine. Annual single dose required during Flu Season.	Flu Vaccine: Date of injection: _____/_____/_____
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.	☐ Pfizer (2) dose vaccine: ☐ Moderna (2) dose vaccine ☐ Johnson & Johnson/Janssen (1) dose vaccine ☐ WHO Approved COVID-19 (2) dose vaccine - Name of Vaccine: _____ Date of injection: _____/_____/_____ (1) Date of injection: _____/_____/_____ (2) ☐ COVID-19 Booster vaccine - Name of Vaccine: _____ Date of injection: _____/_____/_____ (1)
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	☐ Tuberculin Skin Test: Date Placed: _____/_____/_____ Date read: _____/_____/_____ Results: ☐ Negative ☐ Positive ☐ Quantiferon or T-Spot Date Test Given: _____/_____/_____Results: ☐ Negative ☐ Positive ☐ Chest X-Ray: Results: ☐ Negative ☐ Positive Date read: _____/_____/_____ ☐ Treatment for TB or LTBI Date treatment started: _____/_____/_____ Date treatment completed: _____/_____/_____ Name of medication: _____

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 <u>CURRENTLY</u> 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: _____

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 **www.VerifyStudents.com** 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: 112489092

NOTE: A unique login will be emailed to you. This will allow you to log back into **www.VerifyStudents.com** 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 Nursing Programs

Samples available at school for sizing.

www.americandiscountuniform.com

ORDER ONLINE - 24/7

1-866-339-5177 EXT 100

Garments are customized - please allow 3 weeks for delivery.

ALL EMBLEMS (PATCHES) SEWN ON THE UNIFORMS FOR YOUR CONVENIENCE.

Women's Uniforms

RN Program

Ladies Collared Tunic	XS-XL	$34.98
white with forest piping	2X-3X	$36.98
with emblem	4X-5X	$38.98
Required		

Women's 3/4	XS-XL	$23.98
White Lab Coat	2X-3X	$25.98
with emblem	4X-5X	$27.98
USED FOR BOTH RN AND LPN PROGRAMS		

LPN Program

White Collared Tunic with	XS-XL	$34.98
custom green trim	2X-3X	$36.98
with emblem	4X-5X	$38.98
Required		

Name Tag :	
Standard Healthcare	$7.98
Student Name	
Student Nurse	
USED FOR BOTH RN AND LPN PROGRAMS	

Women's White Pants

Ladies Elastic Waist	XS-XL	$15.99
White Pant	2X-3X	$17.99
Available in Reg, petite and tall.		
Optional		

Ladies Flare	XS-XL	$15.99
White Pant	2X-3X	$17.99
Available in Reg, petite and tall.		
Optional		

Men's Uniforms

RN Program

Men's Zipper Top	32-44	$34.98
white	44-48	$36.98
with emblem	50-52	$38.98
Required		

Men's 3/4	XS-XL	$23.98
White Lab Coat	2X-3X	$25.98
with emblem	4X-5X	$27.98
USED FOR BOTH RN AND LPN PROGRAMS		

LPN Program

Men's Zipper Top	XS-XL	$34.98
white with green trim	2X-3X	$36.98
with emblem (EMP-SHC LPN)	4X-5X	$38.98
Required		

Name Tag :	
Standard Healthcare	$7.98
Student Name	
Student Nurse	
USED FOR BOTH RN AND LPN PROGRAMS	

Men's White Pants

Unisex Drawstring Pant	XS-XL	$13.99
White	2X-5X	$15.99
Available in Reg, short and tall.		
Optional		

Men's Cargo Pant	XS-XL	$19.99
White	2X-5X	$21.99
Available in Reg, short and tall.		
Optional		

Place your orders on-line at www.americandiscountuniform.com

Go to www.americandiscountuniform.com, In the top right hand corner click "Group Sign In"

Enter your group code "STANDN" to place orders

Medical accessories and shoes may also be available on the website.

Or CALL 866-339-5177 x 100 - We will be happy to help you.

Orders will be shipped to the home via UPS. For orders under $100 the UPS shipping fee is $9.99.

For orders over $100 - a graduated UPS shipping fee will apply.

We accept credit cards, checks, cash and money orders for payment.

RETURN POLICY: CUSTOMIZED GARMENTS (THOSE WITH EMBLEMS OR MONOGRAMMED) ARE NOT RETURNABLE. THANK YOU.

Women's Apparel

	XXS	XS	S	M	L	XL	2XL	3XL	4XL	5XL
Bust	30-31	32-33	34-35	36-37	38-40	41-44	45-48	49-52	53-56	57-60
Waist	22-23	24-25	26-27	28-30	31-33	34-37	38-41	42-45	46-49	50-53
Hip	32-33	34-35	36-37	38-40	41-43	44-47	48-51	52-55	56-59	60-63

Petite's-under 5'4" / Tall-over 5'8".
Women's inseams approximately 31"/Petite inseams approximately 28"
Tall inseams approximately 33"

Men's Apparel

	XS	S	M	L	XL	2XL	3XL	4XL	5XL
Chest	30-32	34-36	38-40	42-44	46-48	50-52	54-56	58-60	62-64
Waist	24-26	28-30	32-34	36-38	40-42	44-46	48-50	52-54	56-58

American Discount Uniform, Inc. 912 New York Ave., Lower Burrell, PA 15068

email : info@americandiscountuniform.net

www.americandiscountuniform.com