Policy Title: Professional Program Requirements

Policy: In order to be enrolled in the Beth-El College of Nursing Undergraduate Nursing Department professional courses, students must demonstrate compliance with the professional program requirements according to the time frames and specifications stated below.

Background Check
A criminal background check is required of all students (see Background Check Policy).

Drug Testing
Drug testing must be completed by students as specified per BSN Option in the Student Drug Testing Policy.

The following requirements must be completed, and the appropriate documentation uploaded into MyClinicalExchange by the published due date each semester. Documentation must be provided prior to the date specified or the student will be administratively dropped from the course. All documentation must be current and not expire during the clinical course.

Health Insurance
Students must provide documentation of current healthcare insurance.

Cardiopulmonary Resuscitation
Students must provide documentation of current American Heart Association or American Red Cross Basic Life Support Healthcare Provider CPR with the demonstration portion taken in a classroom (not online) setting. Students are responsible for locating all training and renewal classes. If CPR certification expires during a clinical course, then it must be renewed prior to the beginning of the course.

Tuberculosis Screening
1. Baseline testing
   All new nursing students will complete baseline testing for Mycobacterium tuberculosis infection.
   Baseline testing consists of one of the following:
   a. A two-step tuberculin skin test (TST),
   b. A single Blood Assay for Mycobacterium tuberculosis (BAMT), or
c. Documentation of previous positive testing for tuberculosis

**Two-step TST:** The two-step TST consists of an initial TST, read 48 – 72 hours after placement, with results recorded in mm of induration. A second TST is then placed one to three weeks after the initial test and read 48 – 72 hours after placement. Documentation of a negative TST within the previous 12 months can be substituted for the initial TST. The second TST is not placed, if the first TST is positive.

**BAMT:** Blood assays for *Mycobacterium tuberculosis* used in the United States are the QuantiFERON®-TB Gold In-Tube test and the T-SPOT®. TB test. A single BAMT is sufficient for baseline testing. BAMT’s are helpful in persons’ who have received BCG (bacille Calmette-Guérin) vaccine, as BCG does not cause a false-positive BAMT.

**Documentation of previous positive:** Students who provide documentation of a previously positive TST or BAMT or documentation of completed treatment for latent tuberculosis infection or tuberculosis disease do not need to undergo further baseline testing for tuberculosis. Students who have received BCG vaccine and have a history of a positive TST may wish to consider having a BAMT.

2. **Positive Tests**

Any student who has a positive (current or previous) TST or BAMT must complete a symptom screen (Attachment A) and be evaluated by a primary care provider to rule out active tuberculosis disease (Attachment B).

3. **Serial Follow-up Testing**

Students with negative baseline testing must have a single TST or BAMT every year to rule out tuberculosis infection. Students who have positive follow-up testing must be evaluated as above.

Students with previous positive tests must complete a symptom screen every year (Attachment A). Students with symptoms consistent with tuberculosis must be evaluated by a health care provider and provide documentation of the evaluation.

**Immunizations**

Students must provide a legible copy of the Certificate of Immunization. Series immunizations must be documented in chronological order with the most recent immunizations in the farthest right spots. The Certificate must be completed by their health care provider, which meets the following requirements:

1. **Measles, Mumps and Rubella:** 2 (two) MMR’s (or written evidence of laboratory tests showing positive titers of all three immunities: measles, mumps and rubella). This is not required if student was born before January 1, 1957.

2. **Tetanus:** Documentation of a tetanus containing vaccine every 10 years (for example: Td, Tdap). DT and DTaP are not recommended for adults, but still meet the requirement for a tetanus containing vaccine.

3. **Pertussis:** Documentation of one pertussis containing vaccine as an adult (age 19+).

4. **Hepatitis B** series. The three-injection series takes four months to complete. Students in the traditional option must initiate the series before starting NURS 2100, and complete the series before starting NURS 2200. Accelerated option students must have the first two injections completed prior to starting NURS 2200, and will need to complete the series during NURS 2200 by the date instructed by the lead faculty. The schedule for the
Hepatitis B series is as follows: Injection 1, wait 1 month, Injection 2, wait three months, Injection 3.

5. **Varicella (Chicken Pox).** Students must have a documented history of a two-injection varicella immunization series OR a documented laboratory result indicating immunity to varicella.

6. **Influenza (Flu)** immunization. Students must receive this immunization annually.

7. Students must upload records of the above into MyClinicalExchange by the published due dates.

**Procedure:** The student will provide documentation as instructed by policy and follow any additional instructions from the lead faculty member for NURS 2100, the lead faculty member of any clinical course, the Undergraduate Nursing Department Program Administrative Assistant, or the Undergraduate Nursing Department Chairperson.

**Rationale:** In order to provide a safe environment for students, faculty, the community, and patients/clients, students must meet the minimum requirements of the nursing discipline for safety and the prevention of transmission of communicable diseases.

**Key Words:** Professional program requirements, health documentation, immunizations, CPR, background check, drug screening, health insurance

**ROUTING:**

<table>
<thead>
<tr>
<th>DATE</th>
<th>To Students, Faculty, Staff as indicated above</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE</td>
<td>For inclusion in Student Handbook</td>
</tr>
</tbody>
</table>
Attachment A
TUBERCULOSIS SYMPTOM SCREEN

Name: ____________________________________________

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Productive cough lasting more than 3 weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unexplained fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unexplained night sweats</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath/chest pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemoptysis (coughing up blood)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unexplained weight loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unexplained fatigue</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I declare that my answers are true to the best of my knowledge. I understand that if I develop any of the above symptoms I must notify the lead instructor and seek medical evaluation.

__________________________________________  ___________
Signature          Date

Reviewed by:

__________________________________________  ___________
Faculty Signature          Date
HEALTH CARE PROVIDER REFERRAL FORM

Date: __________________________

Name: ________________________________________________________________

First                  Last

Date of birth: ____________________________

The above student has had testing consistent with evidence of tuberculosis infection (positive skin testing and/or blood assay for *Mycobacterium tuberculosis*), and needs further evaluation. The CDC recommends:

- Chest x-ray to rule out active pulmonary disease
- Clinical examination to rule out active disease
- Consider treatment for latent TB infection

Guidelines for treatment of latent TB infection can be found at: http://www.cdc.gov/tb/publications/factsheets/treatment/LTBI_treatmentoptions.htm

The above student was evaluated on ___________________________ and found to be free of signs/symptoms of active tuberculosis disease.

____________________________________________________  _________________
Signature of Health Care Provider      Date
Hepatitis B Vaccine Declination

I, ____________________________________ understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine. Many hospitals and clinical agencies where I will have student experiences require this immunization. However, I decline hepatitis B vaccine at this time. I understand that by refusing to receive this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. Since I will continue to have occupational exposure to blood or other potentially infectious materials, I may have the vaccine later and will inform the College of my status.

_______________________________________________   _______________________
Name          Date

______________________________________________  _______________________
Witness         Date

Employee Health/Infection Control

May 1992