MENNONITE COLLEGE OF NURSING
Illinois State University

Health and Safety Compliance Requirements for Fall 2016 Freshman Students

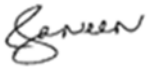
Dear Freshman Nursing Student:

Enclosed is a packet of information relating to health, safety, and compliance requirements for ALL students who are entering Mennonite College of Nursing at Illinois State University in Fall 2016. This packet contains very important health information with specific deadlines.

- Pages 2 – 3 include a snapshot of health requirement deadlines, specific to your plan of study.
- Pages 4 – 9 include a Checklist with detailed descriptions and due dates for each health, safety, and compliance requirement.
- Page 10 is the *Mennonite College of Nursing – Student Health Services Disclosure Consent* form due to Mennonite College of Nursing by October 31, 2016.
- Pages 11 – 13 include instructions for initiating the Criminal Background Check and Drug Testing Policy.
- Page 14 is the *Authorization for Criminal Background Investigation Disclosure Consent Form*
- Pages 15 – 17 include the *Physical Examination Form, Mennonite College of Nursing - Illinois State University* and *Latex Allergy Screening Tool*.
- Pages 18 – 23 is the *Medical Evaluation Questionnaire*.
- Page 24 is the *Medical Determination for Respirator Use* form.

It is important to complete these requirements during the specified timeframes and by the prescribed deadlines. Failure to do so by the designated due dates may result in subsequent registration blocks, a minimum $50.00 administrative compliance fee, and an inability to participate in clinical/practicum/residency activities until the deficiencies are complete. Should you have questions about these requirements, please contact mcnstudenthealth@ilstu.edu.

Sincerely,



Janeen Mollenhauer, M.S., LCPC
Assistant, Dean, Student and Faculty Services
Mennonite College of Nursing
Illinois State University

Mennonite College of Nursing
Health Requirements Checklist
Snapshot of Deadlines

Fall 2016 Plan 1 Students		Adult I Spring 2018
	Documentation Deadline	**Requirement**
☐	**10/31/2016**	Mennonite College of Nursing (MCN) – Student Health Services (SHS) Disclosure Consent Form
☐	**5/5/2017**	TDAP documentation
☐	**5/5/2017**	Hepatitis B Injection Series
☐	**5/5/2017**	Hepatitis B Surface Antibody Titer Lab Report
☐	**5/5/2017**	MMR documentation
☐	**5/5/2017**	Rubella Immunoglobulin G (IgG) Titer Lab Report
☐	**5/5/2017**	Varicella Immunoglobulin G (IgG) Titer Lab Report
☐	**7/7/2017**	Criminal Background Investigation Disclosure Consent Form
☐	**7/7/2017** (background check to be completed between June 1, 2017 – June 30, 2017)	Criminal Background Check
☐	**7/7/2017** (drug test to be completed between June 1, 2017 – June 30, 2017)	Drug Test
☐	**10/31/2017** (course to be completed between May 1, 2017 – July 31, 2017)	Healthcare Provider CPR Course
☐	**10/31/2017** (to be completed no sooner than August 1, 2017)	Physical Examination
☐	**10/31/2017**	Ishihara Color Vision Test
☐	**10/31/2017**	Latex Allergy Screening
☐	**10/31/2017**	Respirator Fit Test
☐	**10/31/2017**	Second round of Hepatitis B Injection Series (if needed) ***at least the first 2 must be completed to be able to register and participate in your clinicals***
☐	**10/31/2017**	Follow-up Hepatitis B Surface Antibody Titer (if you needed to complete a second round of the injection series)
☐	**10/31/2017**	Follow-up MMR injections (if needed)
☐	**10/31/2017**	Follow-up Varicella injections (if needed)
☐	**10/31/2017**	Influenza Vaccination
☐	**12/1/2017** (to be completed no sooner than October 30, 2017)	Two Step Tuberculosis Skin Test

Mennonite College of Nursing
Health Requirements Checklist
Snapshot of Deadlines

Fall 2016 Plan 2 Students		Adult 1 Fall 2018
	Documentation Deadline	**Requirement**
☐	**10/31/2016**	Mennonite College of Nursing (MCN) – Student Health Services (SHS) Disclosure Consent Form
☐	**10/31/2017**	TDAP documentation
☐	**10/31/2017**	Hepatitis B Injection Series
☐	**10/31/2017**	Hepatitis B Surface Antibody Titer Lab Report
☐	**10/31/2017**	MMR documentation
☐	**10/31/2017**	Rubella Immunoglobulin G (IgG) Titer Lab Report
☐	**10/31/2017**	Varicella Immunoglobulin G (IgG) Titer Lab Report
☐	**10/31/2017**	Influenza Vaccination
☐	**11/17/2017**	Criminal Background Investigation Disclosure Consent Form
☐	**11/17/2017** (background check to be completed between Oct 15, 2017 – Nov 15, 2017)	Criminal Background Check
☐	**11/17/2017** (drug test to be completed between Oct 15, 2017 – Nov 15, 2017)	Drug Test
☐	**8/3/2018** (course to be completed between May 1, 2018 – July 31, 2018)	Healthcare Provider CPR Course
☐	**4/20/2018** (to be completed no sooner than March 1, 2018)	Physical Examination
☐	**4/20/2018**	Ishihara Color Vision Test
☐	**4/20/2018**	Latex Allergy Screening
☐	**5/4/2018**	Respirator Fit Test
☐	**8/3/2018** (to be completed no sooner than July 1, 2018)	Two Step Tuberculosis Skin Test
☐	**8/3/2018**	Second round of Hepatitis B Injection Series (if needed) ***at least the first 2 must be completed to be able to register and participate in your clinicals***
☐	**8/3/2018**	Follow-up Hepatitis B Surface Antibody Titer (if you needed to complete a second round of the injection series)
☐	**8/3/2018**	Follow-up MMR injections (if needed)
☐	**8/3/2018**	Follow-up Varicella injections (if needed)

Health Requirements Checklist

Mennonite College of Nursing (MCN) – Student Health Services (SHS) Disclosure Consent Form

In order to work collaboratively with the Illinois State University Student Health Services (SHS) regarding the completion of student immunization requirements, students must authorize the release of protected health information by MCN for this purpose. Students must sign the consent form in this packet and return it to the College.

☐ **MCN – SHS Disclosure Consent Form (page 10)**

Tetanus-Diphtheria-Pertussis Vaccination

Students must have obtained a Tetanus-Diphtheria-Pertussis (TDAP) vaccination since 2007. Re-vaccination of TDAP is required every 10 years.

☐ **Documentation of date of Tetanus-Diphtheria-Pertussis (TDAP) injection 2007 or later**

You may have submitted proof of a Tetanus-Diphtheria (Td) injection to ISU SHS upon admission. Please note that if you have not had the TDAP, you will need this for MCN. If you submitted proof of having received the TDAP to ISU SHS, you must submit this separately to MCN or request that SHS Health Information Management (HIM) send this to MCN.

Hepatitis B Injection Series *and* Hepatitis B Surface Antibody Titer

All students must submit documentation showing receipt of three Hepatitis B injections AND titer lab report results.

☐ **Documentation of dates of all three injections of the series**

You may have completed the series as a child. If so, this can be found on your immunization record and will be acceptable to submit.

☐ **Hepatitis B Surface Antibody Titer Lab Report**

Titer lab reports must show your name, date of the titer, and numerical values and reference ranges. A clear statement regarding your immunity is acceptable provided that the name, credentials, and signature of the healthcare provider who assessed the result is also documented. **If your titer result is "Negative," "Not Immune," or "Non-reactive," you will need to complete another full round of the Hepatitis B injection series and titer.** ***See "Second round of Hepatitis B Injection Series and Hepatitis B Surface Antibody Titer" (below).***

Second Round of Hepatitis B Injection Series *and* Follow-up Hepatitis B Surface Antibody Titer *(if needed…see "Hepatitis B Injection Series and Hepatitis B Surface Antibody Titer")*

If your Hepatitis B antibody titer result is "Negative," "Not Immune," or "Non-reactive," you will need to complete another full round of the Hepatitis B injection series even if you have completed the series as a child.

☐ **Documentation of dates of all three injections of the series (second round)**

A guideline to the Hepatitis B second round schedule:

- Injection #1 – can be obtained immediately
- Injection #2 – to be obtained 1 month after Injection #1
- Injection #3 – to be obtained 6 months after Injection #1

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At least the first two injections of the series must be completed prior to being able to participate in clinical/practicum/residency activities. Timely completion of the series is required.

☐ **Hepatitis B Surface Antibody Titer Lab Report**

1-2 months after completing the second round of the Hepatitis B series, another Hepatitis B antibody titer should be drawn. **If your titer result is still "Negative," "Not Immune," or "Non-reactive," you will need to complete a Hepatitis B Surface Antigen titer.**

Measles, Mumps, and Rubella Vaccinations *and* Rubella Immunoglobulin G (IgG) Titer

All students are expected to provide proof of immunization against Measles, Mumps, and Rubella, as well as obtain a quantitative IgG antibody blood titer to provide proof of immunity to Rubella. Even if you have been immunized or show evidence of having had this disease, you will need to obtain this titer – ***no exceptions***.

☐ **Documentation of dates of two Measles, Mumps, and Rubella (MMR) injections after one year of age and after 12/31/1968**

You submitted this information to ISU SHS upon admission; however, you must submit this separately to MCN or request that SHS HIM send this to MCN.

If you have not had two MMR injections, you are considered in compliance with the MMR requirement if you have had all of the following:

- Two Measles immunizations
  after one year of age and after 12/31/1967
- One Mumps immunization
  after one year of age and after 12/31/1967
- One Rubella immunization
  after one year of age and after 12/31/1968

If you cannot produce proof of two MMR injections, you are considered in compliance with the MMR requirement if you can provide all of the following:

- Positive Measles (Rubeola) IgG titer
- Positive Mumps IgG titer
- Positive Rubella IgG titer

☐ **Rubella Immunoglobulin G (IgG) Titer Lab Report**

Titer lab reports must show your name, date of the titer, and numerical values and reference ranges. A clear statement regarding your immunity is acceptable provided that the name, credentials, and signature of the healthcare provider who assessed the result is also documented. **If your Rubella IgG titer result is "Negative," "Not Immune," or "Equivocal," you will need to complete two follow-up MMR injections even if you have received them in the past.** ***See "Follow-up Measles, Mumps, and Rubella Vaccinations" (below).***

Follow-up Measles, Mumps, and Rubella Vaccinations

If your Rubella IgG titer result is "Negative," "Not Immune," or "Equivocal," you will need to complete two follow-up MMR injections even if you have received them in the past.

☐ **Documentation of dates of two follow-up MMR injections**

- Injection #1 – can be obtained immediately
- Injection #2 – to be obtained 1 month after Injection #1
- *No additional titer is required after completing the follow-up injections.*

Varicella Immunoglobulin G (IgG) Titer

All students are expected to obtain a quantitative IgG antibody blood titer to provide proof of immunity to Varicella. Even if you have been immunized or show evidence of having had this disease, you will need to obtain this titer – ***no exceptions***.

☐ **Varicella Immunoglobulin G (IgG) Titer Lab Report**

Titer lab reports must show your name, date of the titer, and numerical values and reference ranges. A clear statement regarding your immunity is acceptable provided that the name, credentials, and signature of the healthcare provider who assessed the result is also documented. **If your Varicella IgG titer result is "Negative," "Not Immune," or "Equivocal," you will need to complete two follow-up Varicella injections even if you have received them in the past or have had Chicken Pox.** ***See "Follow-up Varicella Vaccinations" (below).***

Follow-up Varicella Vaccinations

If your Varicella IgG titer result is "Negative," "Not Immune," or "Equivocal," you will need to complete two follow-up Varicella injections even if you have received them in the past.

☐ **Documentation of dates of two follow-up Varicella injections**

- Injection #1 – can be obtained immediately
- Injection #2 – to be obtained 1 month after Injection #1
- *No additional titer is required after completing the follow-up injections.*

Healthcare Provider CPR Course

To comply with student requirements of local hospitals, ***all students*** are required to complete one of two approved CPR courses *annually*, even though the CPR card may indicate it is valid for two years.

When researching CPR courses, please be sure to verify the course is ***CERTIFIED*** by either the American Heart Association or the American Red Cross and includes an in-person skills check. Environmental Health and Safety department is now offering on-campus American Heart Association courses for students. Please follow this link to find courses: **https://appointments.illinoisstate.edu/amonline/default.aspx?AG=698**. Students may also contact local hospitals, fire departments, the American Heart Association or the American Red Cross for courses offered in their area.

☐ **Documentation of completion of Healthcare Provider CPR course**

*The **ONLY** acceptable courses are the following:*

- American Heart Association: Basic Life Support (BLS) for Healthcare Providers
  Or
- American Red Cross: Basic Life Support (BLS) for Healthcare Providers

****Lifeguard CPR, Heartsaver, Adult/Child CPR/AED certifications, etc. will **NOT** be accepted. If you have an Advanced Cardiovascular Life Support (ACLS) certification or are currently a BLS CPR instructor, please contact me.*

Criminal Background Check and Drug Testing

Every student must obtain a criminal background check and drug test through the College-designated vendor. Criminal background checks and drug tests completed outside the designated timeframe will ***NOT*** be accepted. Students should begin this process immediately within the assigned window specific to plan of study, as the results can take a lengthy period of time to obtain.

Detailed instructions for ordering both the criminal background check and the drug test are included in this packet, as well as the policy relating to the criminal background check process (pages 11-13).

***Students with disqualifying legal charges and/or positive drug tests
will not be allowed to start the nursing major – ***no exceptions***.***

Note: An additional criminal background check involving fingerprinting may be required prior to enrollment in Nursing Care of Children (NUR 317) and Public Health (NUR 329).

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The cost for this additional background check includes a minimum charge of $52.00. Arrangements for collecting fingerprints and payment will be conveyed to students in the semester prior to their clinical assignment in the schools. In the event a school rejects a student for placement because of criminal background history, the student may not be able to complete program requirements.

☐ **Criminal Background Investigation Disclosure Consent Form (page 14)**

☐ **Authorization for Background Check – Child Abuse and Neglect Tracking System (CANTS) form (this will print from the Verify Students website)**

☐ **Criminal Background Check and Drug Test (page 11)**

*The **ONLY** acceptable method of completing this is using the following procedure:*

- Log on to www.verifystudents.com within the designated timeframe for your plan of study.
- Complete the form entitled "*Authorization for Background Check – Child Abuse and Neglect Tracking System (CANTS)*". This CANTS form must be completed and submitted to MCN as soon as possible, as the results of the background check can take a lengthy period of time to obtain. On your behalf, MCN will send your CANTS form to DCFS for processing. This allows for a faster turnaround. Please do ***not*** alter the address in the bottom left corner of the form, which indicates to DCFS that the results should be sent to Corporate Screening Services, Inc. DCFS will ***not*** accept electronic signatures.
- You will be directed to obtain a drug test at an approved clinic closest to your requested zip code. After paying online, you must complete the drug test ***within three days***.
- Results from the criminal background check and drug test are communicated electronically by the vendor to the College.

Tuberculosis Test

All students are expected to complete a Tuberculosis exposure screening test from a primary care provider, health department, or occupational health clinic. ***ALL STUDENTS*** *are required to have a TB test annually*.

☐ **Documentation of Two-Step TB Skin Test**

This consists of 4 appointments:

- Test 1 administered
- Test 1 read – 48-72 hours after Test 1 administered
- Test 2 administered – 1-3 weeks after Test 1 administered
- Test 2 read – 48-72 hours after Test 2 administered. This test must not be read prior to the first date of the specified window in order to be in compliance with this requirement.

****Documentation must include the dates administered and read, and the results. If you have had a Two-Step TB Skin Test in the past, please contact me to determine if you will need a Two-Step or One-Step.****

or

☐ **Quantiferon Gold TB Test Lab Report**

or

☐ **T-SPOT.TB Test Lab Report**

Physical Examination

All students are expected to receive a physical examination by a physician/nurse practitioner. The physical examination requires you to provide your physician/nurse practitioner with information regarding your physical limitations. Awareness of your physical limitations will help us enable you to succeed in the program and ensure patient safety. Nursing is a rigorous profession requiring physical flexibility and mobility (i.e., lifting patients, moving equipment, and responding quickly in emergencies). Your honest disclosure to the physician/nurse practitioner conducting your physical examination regarding any mobility issues (i.e., a history of back injury with lifting limitations and knee injuries) is a necessity for safe nursing practice. Any student needing to arrange for a reasonable accommodation for a documented disability should contact Student Access and Accommodation Services at 350 Fell Hall (Telephone: 309-438-5853 or TTY: 309-438-8620).

☐ **Physical Examination**

If you go to SHS for your physical

- You will need to make an appointment by calling 309-438-2778. Appointments may be scheduled Monday – Thursday from 8am – 4:30pm or Fridays from 8am – 4pm.
- SHS will send you a link on their secure website to a ***Medical Evaluation Questionnaire*** that you MUST complete ahead of time related to the Respirator Fit Test.
- When you go for your appointment, you will need to bring with you your completed ***Latex Allergy Screening Tool***. Your SHS healthcare provider will sign off on it. Also part of the physical at SHS is your Ishihara color vision test.
- During your visit to SHS, you will need to get a copy of:
  - your physical,
  - the signed Latex Allergy form, and
  - the Medical Determination for Respirator Use form, which SHS will supply.

If you do NOT go to SHS and instead go to another healthcare provider for your physical

- You will need to bring with you:
  - ***Physical Examination Form (pages 15-16)***. Your healthcare provider will need to complete, sign, and date the form. Part of the physical is your Ishihara color vision test. Your healthcare provider should note the results of this on the physical form. If your healthcare provider cannot administer the Ishihara test, you may make an appointment with an ophthalmologist or optometrist for this or get this done at SHS.
  - Your completed ***Latex Allergy Screening Tool (page 17)***. Your healthcare provider must sign.

Respirator Fit Test

Respirators are used to safeguard individuals against accidental inhalation of contaminants such as Tuberculosis, H1N1, Severe Acute Respiratory Syndrome (SARS), Avian influenza, and other infectious and airborne diseases. Every student shall receive a Respirator Fit Test conducted in accordance with OSHA's 1910.134 standard.

☐ **Documentation of Respirator Fit Test**

After you have received the Medical Determination form from your healthcare provider, you must make an appointment with Environmental Health and Safety (EHS) on the ISU campus. Appointments must be made 48 hours in advance by signing up online: https://appointments.illinoisstate.edu/amonline/default.aspx?AG=641

For your appointment at the Nelson Smith Building, you must:

- Bring the MCN-EHS Medical Determination form, which was signed off by your healthcare provider. AND
- Arrange for payment. EHS will not administer the fit test without payment. You can pay using either of the following methods:

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Credit or debit card by paying online ahead of time:
https://secure.touchnet.com/C20868_ustores/web/store_main.jsp?STOREID=74&SINGLESTORE=true
Please be advised: ISU computers cannot be used to make payments. Personal computers and smart phones can be used. Please bring a printed copy of payment confirmation to the appointment.

or

$20.00 check made out to Illinois State University

If you do not pass your Fit Test, EHS will provide Powered Air Purifying Respirator (PAPR) training on site.

If you fail your Fit Test

☐ **Documentation that you have completed PAPR training**

Influenza Vaccination

All students are required to receive the influenza vaccine when it becomes available during flu season *each year*. In September or early October, students should anticipate scheduling this at SHS or at a provider of one's choice.

☐ **Documentation of influenza vaccination**

Documentation may be submitted in person, by mail, fax, or email to:

Lana Blakemore
Mennonite College of Nursing
Illinois State University
112F Edwards Hall
Campus Box 5810
Normal, IL 61790-5810
Phone: 309-438-2463
Fax: 309-438-0591
Email: mcnstudenthealth@ilstu.edu

MENNONITE COLLEGE OF NURSING
Illinois State University

Mennonite College of Nursing – Student Health Services
Disclosure Consent Form

I, (print name) _____, give permission to Mennonite College of Nursing at Illinois State University to provide all or part of the protected health information in my medical record to designated representatives of Illinois State University Student Health Services for the purpose of verifying the completion of student health requirements. A photocopy of this release is as valid as the original.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the individual listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

I understand that this authorization is not reciprocal and that I must sign a separate authorization form at the Health Information Management Department at Illinois State University Student Health Services giving permission for each specific item of health information to be released to Mennonite College of Nursing.

I have had full opportunity to read and consider the contents of this authorization, and I understand that by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information as described in this form.

_____ _____

Student Signature Date

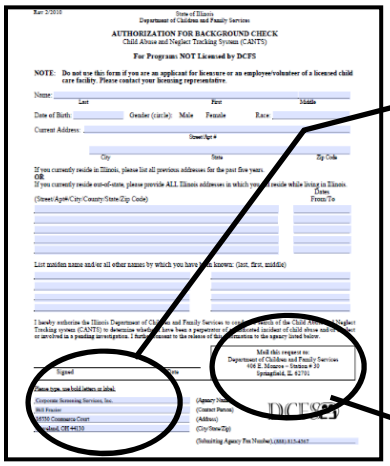
Return to:

Lana Blakemore
Mennonite College of Nursing
Illinois State University
112F Edwards Hall
Campus Box 5810
Normal, IL 61790-5810
Fax: 309-438-0591
Email: mcnstudenthealth@ilstu.edu

MENNONITE COLLEGE OF NURSING
Illinois State University

Criminal Background Check and Drug Screen Instructions

1. Log onto www.verifystudents.com
   - A valid email address is REQUIRED.
   - You must be near a printer to print necessary forms.
   - Have your credit card/debit card (Visa/MasterCard/American Express/Discover) information ready. Your credit card/debit card will be charged **$98.00** for the service.
   - Use this special promotional code: **MENNONITECOLLEGPTBGDS**
   - A unique login will be emailed to you. This will allow you to log back into www.verifystudents.com.
2. Complete profile & e-sign forms as they appear.
3. ***The Child Abuse and Neglect Tracking System (CANTS)*" Form will need a <u>written signature</u>** (sample below):



AUTHORIZATION FOR BACKGROUND CHECK
Child Abuse and Neglect Tracking System (CANTS)

For Programs NOT Licensed by DCFS

NOTE: Do not use this form if you are an applicant for licensure or an employee/volunteer of a licensed child care facility. Please contact your licensing representative.

<u>Please ensure this section of the form includes the following information:</u>

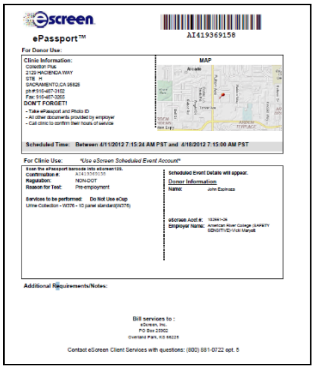
888-818-3273
verifications@corporatescreening.com

Corporate Screening Services, Inc.
Attn: Michelle Chapin or Bill Frazier
16530 Commerce Court
Middleburg Heights, OH 44130

STOP **Submit the CANTS Form to MCN NOT TO DCFS!!** STOP

We will submit your CANTS form to the Illinois Department of Children and Family Services (DCFS) on your behalf.
Submit form to:
Lana Blakemore
Fax: 309-438-0591
Email: mcnstudenthealth@ilstu.edu

4. Schedule your drug test and print your *ePassport* (sample below). You will only have 3 business days to complete your drug test.



ePassport™

5. Go to collection site listed on your ePassport. Take your ePassport and government-issued picture identification (e.g., driver's license) to collection site.

Mennonite College of Nursing at Illinois State University
Policy on Criminal Background Checks

Criminal background checks are becoming standard requirements by many healthcare institutions. Because the clinical experience is an essential component of the curriculum, if you are unable to participate, you could not successfully complete the curriculum. Criminal background checks and fingerprinting are required in many states to apply for licensure. All Mennonite College of Nursing students will be required to complete criminal background checks prior to enrollment. Students who have been convicted of committing or attempting to commit certain crimes specified in the Health Care Worker Background Check Act (225 ILCS 46/25, et seq.) (hereinafter "the Act") may be ineligible to continue in the nursing program. Students who do not give permission to conduct the criminal background check will be barred from enrollment in the nursing program at Mennonite College of Nursing.

Policy:

Mennonite College of Nursing will require that ALL undergraduate and graduate students complete criminal background checks. The criminal background checks will be conducted through a company selected by Mennonite College of Nursing (which may be an online company). Students will pay the cost associated with the background check process. Students receiving a positive criminal background check whose offense prohibits them from being hired by a health care employer under the Act must obtain a waiver from the Illinois Department of Public Health (IDPH) to continue in the nursing program.

Procedure:

1. Upon acceptance to the nursing program, students will be provided detailed information regarding the procedure for completing this requirement.

2. Students will be required to sign a consent form (Authorization for Criminal Background Investigation and Disclosure/Consent Form) that allows the college to conduct the criminal background check and to release results of criminal background checks to clinical agencies upon their request. Failure to sign the consent and provide all necessary information shall result in the student being unable to begin or progress in the nursing program.

3. The criminal background check must be completed by the chosen company no sooner than 60 days prior to enrollment in the nursing program. Students may NOT use similar reports on file at other agencies to satisfy this requirement.

4. Background checks must be completed by the dates specified. Additional checks may be required if: 1) clinical agencies require criminal background checks more frequently or 2) the nursing student interrupts his/her program for one semester or longer. In such cases, the student will be required to have another criminal background check. The college of nursing reserves the right to require an additional background check during the program at the college's discretion.

5. Results of Criminal Background checks must be submitted to the College of Nursing. Results will be confidentially maintained by the College of Nursing separately from their academic record. Results will be maintained until the student graduates from the University.

6. The student is responsible for all fees for background checks. Costs may be subject to change and are beyond the control of the University or the College of Nursing.

Management of Results:

1. The Assistant Dean or designee will access the electronic report from the selected company.

2. A student whose background check results in a status of "no record" may enroll in clinical/ practicum/ residency placement and continue in the nursing program.

3. A student whose background check results in a positive history (a background check that results in a criminal history) will be notified by the Assistant Dean or designee as soon as possible. Students may view their own results on the vendor website.

4. The Assistant Dean or designee will meet with the student to verify whether the criminal record is valid or invalid.

5. If the student believes that a record or conviction is erroneous, the student may request a fingerprint-based background check. The student is responsible for the cost of fees for fingerprint checks. If the fingerprint check reveals no criminal convictions, the student may continue in the nursing program and enroll in clinical/ practicum/ residency courses. **Results must be received prior to the beginning of the semester for the student to remain enrolled.**

6. If the student knows and/or the conviction is found to be valid and the offense is on the "crimes that disqualify" list from IDPH, the student will be required to secure a waiver from IDPH.

7. The student is responsible for contacting IDPH (217-782-2913) for instructions and application for waiver. **The process for a waiver may take several weeks or longer. The student may not enroll in nursing courses prior to attaining the waiver.**

8. The IDPH waiver must be submitted to the Assistant Dean upon receipt.

9. The student may be allowed to continue in the program only after the IDPH waiver has been received by the Assistant Dean. Enrollment will be based on program capacity and availability of courses. If a waiver is not granted, the student will be withdrawn from the nursing program.

10. The college is not responsible for any student being ineligible for coursework, continued enrollment in the program, or subsequent licensure as a registered nurse.

11. The student is responsible for keeping the college updated on any and all changes in his/her criminal background status. False information or failure to disclose correct information at any time may be a basis for dismissal from the program.

Criminal Background Investigation
Disclosure Consent Form

I hereby authorize The Board of Trustees of Illinois State University, on behalf of its Mennonite College of Nursing, (hereafter "Mennonite College of Nursing") or any qualified agent, or clinical facility to receive a copy of my criminal history background. This criminal background investigation must be conducted and is for the purpose of assisting Mennonite College of Nursing and clinical facilities in evaluating my suitability for clinical experiences. The release of information pertaining to this criminal background investigation to those persons necessary to determine my suitability to participate in the clinical education experience is expressly authorized.

I understand that information contained in the criminal background report may result in my being denied a clinical experience and may result in dismissal from the nursing program. If negative information is contained in my report, I understand that I will be notified by Mennonite College of Nursing and I have the right to contest the accuracy of the report.

If a facility refuses the student access to the clinical experience at its facility, Mennonite College of Nursing will make reasonable efforts to find an alternative site for the student to complete the clinical experience. A student who cannot be reasonably assigned will be dismissed from the program.

I hereby give Mennonite College of Nursing permission to obtain and release criminal background information to facilities to which I may be assigned for clinical experience prior to beginning the assignment. I hereby release The Board of Trustees of Illinois State University and Mennonite College of Nursing, its trustees, employees, agents, and assigns, from any and all claims including but not limited to, claims of defamation, invasion of privacy, negligence or any other damages resulting from or pertaining to the collection and dissemination of this information. I understand that I am responsible for all costs associated with this process.

I also agree that any future criminal convictions will be reported immediately to the Mennonite College of Nursing Assistant Dean. Failure to report future criminal convictions may result in program dismissal.

My signature below certifies that all information given is true and reliable. Any false information given or refusal to adhere to the clinical background investigation will result in dismissal from the nursing program.

_____ _____

Printed Full Name Signature

_____

Date

Please sign and return this form to:

Lana Blakemore
Mennonite College of Nursing
Illinois State University
112F Edwards Hall
Campus Box 5810
Normal, IL 61790-5810
Fax: 309-438-0591
Email: mcnstudenthealth@ilstu.edu

Physical Examination Form

Mennonite College of Nursing - Illinois State University

This form is to be completed by a physician or nurse practitioner

_____ _____ _____

Last Name First Name MI

_____ _____ _____

Date of Birth (mo/day/yr) UID Program (Traditional BSN, Accelerated BSN, RN/BSN, MSN, PhD, DNP)

	NORMAL	ABNORMAL	COMMENTS
Skin			
Ears			
Eyes			
Nose			
Throat			
Mouth/Dental			
Cardiovascular			
Respiratory			
Gastrointestinal			
Neurological			
Musculoskeletal			
Spinal Examination			
Nutritional Status			
Other			

Height_____Weight_____ Blood Pressure_____ Pulse_____ Respiration_____Vision L/R_____/_____

Ishihara: _____

TDAP date: _____

Titers Required: **IN ADDITION, MUST BE ACCOMPANIED BY EACH TITER LAB REPORT**

_____	_____	_____
Hepatitis B Surface Antibody titer date	**Rubella IgG titer date**	**Varicella IgG titer date**

Hepatitis B: Dates of the 3 injections: #1_____ #2_____ #3_____

(Continued on Next Page)

Student Name_____ UID_____

Please indicate below if the student has had or is subject to having the following conditions and provide additional information, when available, regarding the course of treatment for the condition(s).

_____ Seizure Disorders_____
_____ Diabetes_____
_____ Asthma_____
_____ Shortness of Breath_____
_____ Allergies/ drug – food - latex_____
_____ Hay fever, Eczema_____
_____ Cough, Chronic Hoarseness_____
_____ Heart Disease_____
_____ History of Smoking_____
_____ Low/High Blood Pressure_____
_____Hernia_____
_____
Major Surgery
_____

What medications are taken on a regular basis?

_____

Do you know of any medical condition or physical limitation that would limit the student's ability to engage in clinical nursing behaviors or academic participation? ❑ NO ❑ YES

Explain_____

_____

Print Provider Name and Credentials	**Provider Signature** (Physician or Nurse Practitioner)	**Date**
Name of Clinic/Provider Address	**Provider Telephone Number with Area Code**	

Latex Allergy Screening Tool

These questions are designed to help your physician determine if you may have a Latex sensitivity.

Name: _____

Signature: _____ Date: _____

Please complete the following:	Yes	No
Have you ever had an allergic reaction to latex or rubber products?		
If so, is your doctor aware of this allergy?		
Have you ever been tested for a latex allergy?		
Have you ever had a reaction in your mouth after dental work, such as sores, etc?		
Does your job/occupation involve contact with products, which contain latex rubber?		

If "Yes" is checked for any of the below, a physician must review and sign this form.
If "No" is checked, a nurse may review and sign this form.

Have you had a reaction to any of the following sources of latex/rubber?

	Yes	No		Yes	No
Balloons			Rubber Gloves		
Hot water bottles			Rubber bands, balls		
Foam pillows			Baby bottles, nipples		
Pacifiers			Shoes		
Erasers			Elastic bandages		
Face masks			Medical devices such as catheters		
Adhesive tape, Band-Aids			Latex rubber birth control devices (condoms, diaphragm, etc.)		
Clothing with elastic or stretch clothes (belts, bras, suspenders, elastic waistbands)			Other:		

After handling latex products, have you had any of the following?

	Yes	No		Yes	No
Difficulty breathing, wheezing			Runny nose/congestion		
Chapping or "cracking" of hands			Itching (e.g., of hands, eyes), rash		
Hives			Redness		
Swelling of the body, tongue or face			Excessive tearing or reddened eyes		
Low blood pressure			Other:		

Do you have a history any of the following?

	Yes	No		Yes	No
Contact dermatitis			Asthma, bronchitis		
Hay fever			Eczema		
Disease of the immune system (such as lupus, etc.)					

Do you have any food allergies?

	Yes	No		Yes	No
Bananas			Kiwi		
Avocados			Chestnuts		
Papaya			Potatoes		
Tomatoes			Peaches		
Almonds			Celery		
Figs			Corn Products		
Other:			Other:		

Print Provider Name and Credentials_____

Provider Signature_____

Latex Allergy Risk
Check One:

❑ High ❑ Low

Medical Evaluation Questionnaire from 29CFR1910.134, Appendix C
Respiratory Protection

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee: Your employer must allow you to answer this questionnaire during normal working hours or at a time and place that is convenient for you. To maintain your confidentiality, your employer or supervisor must not see your answers. Your employer will tell you how to deliver this questionnaire to the health-care professional who will review it.

Part A. Section 1. Mandatory

The following information must be provided by every employee who has been selected to use any type of respirator. (Please print.)

1. Today's date:
2. Your name:
3. Your age (*to nearest year*):
4. Sex (*check one*): ☐ Male ☐ Female
5. Your height: feet inches
6. Your weight: pounds
7. Your job title:
8. A phone number where you can be reached by the health-care professional who reviews this questionnaire (*Include area code.*):
9. The best time to phone you at this number:
10. Has your employer told you how to contact the health-care professional who will review this questionnaire? (*Check one.*) ☐ Yes ☐ No
11. Check the type of respirator you will use (you can check more than one category):
    - ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
    - ☐ Other type (for example, half- or full-facepiece type, powered air-purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator? (*Check one.*) ☐ Yes ☐ No

    If yes, what type(s):

Part A. Section 2. Mandatory

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator. (Check "yes" or "no.")

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? ..... ☐ Yes ☐ No
2. Have you ever had any of the following conditions?
    - a. Seizures (*fits*): ..... ☐ Yes ☐ No
    - b. Diabetes (*sugar disease*) ..... ☐ Yes ☐ No
    - c. Allergic reactions that interfere with your breathing ..... ☐ Yes ☐ No
    - d. Claustrophobia (*fear of closed-in places*) ..... ☐ Yes ☐ No
    - e. Trouble smelling odors ..... ☐ Yes ☐ No
3. Have you ever had any of the following pulmonary or lung problems?
    - a. Asbestosis ..... ☐ Yes ☐ No
    - b. Asthma ..... ☐ Yes ☐ No

c. Chronic bronchitis ☐ Yes ☐ No

d. Emphysema ☐ Yes ☐ No

e. Pneumonia ☐ Yes ☐ No

f. Tuberculosis ☐ Yes ☐ No

g. Silicosis ☐ Yes ☐ No

h. Pneumothorax (collapsed lung) ☐ Yes ☐ No

i. Lung cancer ☐ Yes ☐ No

j. Broken ribs ☐ Yes ☐ No

k. Chest injuries or chest surgeries ☐ Yes ☐ No

l. Any other lung problem that you've been told about ☐ Yes ☐ No

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

a. Shortness of breath ☐ Yes ☐ No

b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline ☐ Yes ☐ No

c. Shortness of breath when walking with other people at an ordinary pace on level ground ☐ Yes ☐ No

d. Do you have to stop for breath when walking at your own pace on level ground ☐ Yes ☐ No

e. Do you have shortness of breath when washing or dressing yourself ☐ Yes ☐ No

f. Do you have shortness of breath that interferes with your job ☐ Yes ☐ No

g. Do you have coughing that produces phlegm (thick sputum) ☐ Yes ☐ No

h. Do you have coughing that wakes you early in the morning ☐ Yes ☐ No

i. Do you have coughing that occurs mostly when you are lying down ☐ Yes ☐ No

j. Have you coughed up blood in the last month ☐ Yes ☐ No

k. Do you wheeze ☐ Yes ☐ No

l. Do you have wheezing that interferes with your job ☐ Yes ☐ No

m. Do you have chest pain when you breathe deeply ☐ Yes ☐ No

n. Do you have any other symptoms that you think may be related to lung problems ☐ Yes ☐ No

5. Have you ever had any of the following cardiovascular or heart problems?

a. Heart attack ☐ Yes ☐ No

b. Stroke ☐ Yes ☐ No

c. Angina ☐ Yes ☐ No

d. Heart failure ☐ Yes ☐ No

e. Swelling in your legs or feet (not caused by walking) ☐ Yes ☐ No

f. Heart arrhythmia (*heart beating irregularly*) ☐ Yes ☐ No

g. High blood pressure ☐ Yes ☐ No

h. Any other heart problem that you've been told about ☐ Yes ☐ No

6. Have you ever had any of the following cardiovascular or heart symptoms?

a. Frequent pain or tightness in your chest ☐ Yes ☐ No

b. Pain or tightness in your chest during physical activity ☐ Yes ☐ No

c. Pain or tightness in your chest that interferes with your job ☐ Yes ☐ No

d. In the past two years, have you noticed your heart skipping or missing a beat ☐ Yes ☐ No

e. Heartburn or indigestion that is not related to eating ☐ Yes ☐ No

f. Any other symptoms that you think may be related to heart or circulation problems ☐ Yes ☐ No

7. Do you take medication for any of the following problems?

a. Breathing or lung problems ☐ Yes ☐ No

b. Heart trouble ☐ Yes ☐ No

c. Blood pressure ☐ Yes ☐ No

d. Seizures (fits) ☐ Yes ☐ No

8. If you've used a respirator, have you ever had any of the following problems? (*If you've never used a respirator, go to question 9.*)

a. Eye irritation ☐ Yes ☐ No

b. Skin allergies or rashes ☐ Yes ☐ No

c. Anxiety ☐ Yes ☐ No

d. General weakness or fatigue ☐ Yes ☐ No

e. Any other problem that interferes with your use of a respirator ☐ Yes ☐ No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire ☐ Yes ☐ No

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you ever lost vision in either eye (*temporarily or permanently*) ☐ Yes ☐ No

11. Do you have any of the following vision problems?

a. Wear contact lenses ☐ Yes ☐ No

b. Wear glasses ☐ Yes ☐ No

c. Color blind ☐ Yes ☐ No

d. Any other eye or vision problem ☐ Yes ☐ No

12. Have you ever had an injury to your ears, including a broken ear drum ☐ Yes ☐ No

13. Do you currently have any of the following hearing problems?

a. Difficulty hearing ☐ Yes ☐ No

b. Wear a hearing aid ☐ Yes ☐ No

c. Any other hearing or ear problem ☐ Yes ☐ No

14. Have you ever had a back injury ☐ Yes ☐ No

15. Do you currently have any of the following musculoskeletal problems?

a. Weakness in your arms, hands, legs, or feet ..... ☐ Yes ☐ No

b. Back pain ..... ☐ Yes ☐ No

c. Difficulty moving your arms and legs ..... ☐ Yes ☐ No

d. Pain or stiffness when you lean forward or backward at the waist ..... ☐ Yes ☐ No

e. Difficulty fully moving your head up or down ..... ☐ Yes ☐ No

f. Difficulty fully moving your head side to side ..... ☐ Yes ☐ No

g. Difficulty bending at your knees ..... ☐ Yes ☐ No

h. Difficulty squatting to the ground ..... ☐ Yes ☐ No

i. Climbing a flight of stairs or a ladder carrying more than 25 pounds ..... ☐ Yes ☐ No

j. Any other muscle or skeletal problem that interferes with using a respirator ..... ☐ Yes ☐ No

Part B (Non-Mandatory)

Any of the following questions as well as questions not listed here may be added to the questionnaire at the discretion of the health-care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen? ..... ☐ Yes ☐ No

If yes, do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions? ..... ☐ Yes ☐ No

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals? ..... ☐ Yes ☐ No

If yes, name the chemicals, if you know them:

3. Have you ever worked with any of the materials or under any of the conditions listed below:

a. Asbestos ..... ☐ Yes ☐ No

b. Silica (*e.g., in sandblasting*) ..... ☐ Yes ☐ No

c. Tungsten/cobalt (e.g., grinding or welding this material) ..... ☐ Yes ☐ No

d. Beryllium ..... ☐ Yes ☐ No

e. Aluminum ..... ☐ Yes ☐ No

f. Coal (*for example, mining*) ..... ☐ Yes ☐ No

g. Iron ..... ☐ Yes ☐ No

h. Tin ..... ☐ Yes ☐ No

i. Dusty environments ..... ☐ Yes ☐ No

j. Any other hazardous exposures ..... ☐ Yes ☐ No

If yes, describe these exposures:

4. List any second jobs or side businesses you have:

5. List your previous occupations:

6. List your current and previous hobbies:

7. Have you been in the military services? ..... ☐ Yes ☐ No

If yes, were you exposed to biological or chemical agents (either in training or combat)? ..... ☐ Yes ☐ No

8. Have you ever worked on a HAZMAT team? ..... ☐ Yes ☐ No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (*including over-the-counter medications*)? ..... ☐ Yes ☐ No

If yes, name the medications, if you know them:

10. Will you be using any of the following items with your respirator(s)?

a. HEPA filters ..... ☐ Yes ☐ No

b. Canisters (for example, gas masks) ..... ☐ Yes ☐ No

c. Cartridges ..... ☐ Yes ☐ No

11. How often are you expected to use the respirator(s)? Check yes or no for all answers that apply to you.

a. Escape only (*no rescue*) ..... ☐ Yes ☐ No

b. Emergency rescue only ..... ☐ Yes ☐ No

c. Less than 5 hours per week ..... ☐ Yes ☐ No

d. Less than 2 hours per day ..... ☐ Yes ☐ No

e. 2 to 4 hours per day ..... ☐ Yes ☐ No

f. Over 4 hours per day ..... ☐ Yes ☐ No

12. During the period you are using the respirator(s), is your work effort:

a. Light ..... ☐ Yes ☐ No

If yes, how long does this period last during the average shift? hours: minutes:

Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; standing while operating a drill press (1-3 lbs.) controlling machines.

b. Moderate ..... ☐ Yes ☐ No

If yes, how long does this period last during the average shift? hours: minutes:

Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

c. Heavy ..... ☐ Yes ☐ No

If yes, how long does this period last during the average shift; hours: minutes:

Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator? ..... ☐ Yes ☐ No

If yes, describe this protective clothing and/or equipment:

14. Will you be working under hot conditions? (*temperature exceeding 77°F*) ..... ☐ Yes ☐ No

15. Will you be working under humid conditions? ..... ☐ Yes ☐ No

16. Describe the work you'll be doing while you're using your respirator(s):

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

- Name of the first toxic substance:
- Estimated maximum exposure level per shift:
- Duration of exposure per shift:
- Name of the second toxic substance:
- Estimated maximum exposure level per shift:
- Duration of exposure per shift:
- Name of the third toxic substance:
- Estimated maximum exposure level per shift:
- Duration of exposure per shift:
- Name of any other toxic substances you'll be exposed to while using your respirator:

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (*for example, rescue, or security*):

Medical Determination for Respirator Use
Mennonite College of Nursing

Part I:

Name:	
UID:	DOB:
Expected Date of Graduation:	Today's Date:

Type of Respirator Used – check and circle all that apply

☒ Filtering Face Piece (Particulate, Disposable, Single Use, Dust Mask)

Level of Work Effort

☒ Heavy – Ex. Lifting 50 lbs., climbing with 50 lbs., walking up an 8° grade at 2 mph.

Extent of Usage

☒ Emergency

Special Work Conditions:

☒ Additional protective equipment required: Gloves/ Gown

Part II: (to be completed by physician)

☐ No restrictions on Respirator Use	☐ Temporarily Not Qualified	☐ Not Qualified
Print:		
Sign:		
Date:		

PHYSICIAN: PLEASE PROVIDE A SIGNED COPY TO THE PATIENT:
This Signed copy will need to be taken with you at the time of your FIT testing.