LAMAR UNIVERSITY
COLLEGE OF ARTS AND SCIENCES
JOANNE GAY DISHMAN SCHOOL OF NURSING
PRACTICUM READINESS DOCUMENTS

Students in the Lamar University Nursing Program must be in a state of health that will allow them to participate in all practicum phases of the program of study in a manner that will not jeopardize the health or safety of clients or themselves. Students must complete all three parts of this form and submit any additional requested documentation. All students should have Part III of the form completed by their health care provider or their designee prior to matriculation in the program. Sentry MD will accept separate documentation of individual immunization requirements (see Part II) provided that they are on a healthcare facility form, dated and signed. It is your responsibility to maintain an updated history with Student Check/Sentry MD until your graduation from Lamar University. These records must always be current.

Part I-Student Profile: This data will be used to create your Student Check/Sentry MD account.

<table>
<thead>
<tr>
<th>Name: (Please Print)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last                              First       MI</td>
</tr>
<tr>
<td>Date of Birth: <em><strong>/</strong></em>/____</td>
</tr>
<tr>
<td>Phone: (__<em>) <strong><strong><strong>-</strong></strong></strong></em></td>
</tr>
</tbody>
</table>

| Lamar University Email Address |
| Secondary Email Address |

| Street Address |
| City, State, Zip |

Additional Practicum Readiness Documents to submit:

1. Professional Liability Insurance: Students must carry active Professional Liability Insurance while attending Lamar University. Please submit a copy of your Lamar University receipt confirming your payment to Bill Beatty Insurance for Professional Liability Insurance Coverage.

2. CPR Certification: Students must carry active CPR Certification. Please submit a copy of your American Heart Association CPR card.

Lamar University Department of Nursing works with Student Check/Sentry MD, a confidential health information service. Student Check/Sentry MD maintains and processes all student immunization records and monitors compliance with state and program law requirements.

Students must submit required immunization forms and Practicum Readiness Documents by email to: lamar@sentrymd.com—or upload it directly to the Sentry MD Secure Uploader as a PDF attachment (go to http://mysentrymd.com/sentrymd.html#/upload/26).

The deadline to submit these forms is August 18, 2017.

Please remember it may take up to 3 days to process your documents, so please plan your submission accordingly.
# Lamar University
## College of Arts and Sciences
### Joanne Gay Dishman School of Nursing
#### Practicum Readiness Documents

**Part II- Immunizations:** to be completed by your health care provider, or:

Sentry MD will also accept separate documentation of individual requirements provided that they are on a healthcare facility form, dated and signed.

In order to promote and maintain a safe environment while in the Lamar University Department of Nursing Program and practicum affiliate sites, the following information is required prior to enrollment. **Must not expire** during the semester.

**Submit the forms to Sentry MD by email to:** lamar@sentrymd.com or upload at [http://mysentrymd.com/sentrymd.html#upload/26](http://mysentrymd.com/sentrymd.html#upload/26)  
➤ KEEP A COPY FOR YOUR OWN RECORDS. ➤

<table>
<thead>
<tr>
<th>Vaccine Dates:</th>
<th>Dates (Required):</th>
<th>Results of MMR Titers (Required):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polio: Proof of initial series or Exempt by age</td>
<td>Dose 1: <em><strong>/</strong></em>/____</td>
<td>Immune___ Non-immune____</td>
</tr>
<tr>
<td></td>
<td>Dose 2: <em><strong>/</strong></em>/____</td>
<td>Immune___ Non-immune____</td>
</tr>
<tr>
<td></td>
<td>Dose 3: <em><strong>/</strong></em>/____</td>
<td>Immune___ Non-immune____</td>
</tr>
<tr>
<td></td>
<td>Dose 4: <em><strong>/</strong></em>/____</td>
<td>Immune___ Non-immune____</td>
</tr>
<tr>
<td>Measles, Mumps and Rubella (MMR): Documentation of two doses of vaccine or confirmed immunity by serology or written waiver or letter from primary care provider stating medical reason for exemption.</td>
<td>Dose 1: <em><strong>/</strong></em>/____</td>
<td>Td Booster (no more than 10 yrs. old) <em><strong>/</strong></em>/____</td>
</tr>
<tr>
<td></td>
<td>Measles: (Rubeola): <em><strong>/</strong></em>/____</td>
<td>*if more than 10 yrs. old, then Td booster is required.</td>
</tr>
<tr>
<td></td>
<td>Mumps: <em><strong>/</strong></em>/____</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rubella: <em><strong>/</strong></em>/____</td>
<td></td>
</tr>
<tr>
<td>Tetanus Diphtheria, Pertussis and TdaP: DPT or DTaP - Date of Series</td>
<td>Dose 1: <em><strong>/</strong></em>/____</td>
<td>TdaP Booster*: <em><strong>/</strong></em>/____</td>
</tr>
<tr>
<td></td>
<td>Dose 2: <em><strong>/</strong></em>/____</td>
<td>*if more than 10 yrs. old, then Td booster is required.</td>
</tr>
<tr>
<td>Varicella: Dates of 2 immunizations or confirmed immunity by serology or confirmation of the disease from healthcare provider or official school records or written waiver or letter from primary care provider stating medical reason for exemption</td>
<td>Vaccine 1: <em><strong>/</strong></em>/____</td>
<td>Date of Serology (Titer): <em><strong>/</strong></em>/____</td>
</tr>
<tr>
<td></td>
<td>Varicella 2: <em><strong>/</strong></em>/____</td>
<td>Immune ___ Non-immune ____</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Written waiver or letter: <em><strong>/</strong></em>/____</td>
</tr>
<tr>
<td><strong>Hepatitis B:</strong> Dates of 3 immunizations (primary series) and Laboratory confirmed immunity by serologic testing (if the serologic testing is negative immunity, then the student must take one booster or repeat a 2nd series [3 immunizations] •after repeating the Hep B series or booster, the requirement has been met) or confirmed immunity by serologic testing or written waiver or letter from primary care provider stating medical reason for exemption</td>
<td><strong>Dose 1:</strong></td>
<td><strong>Hep B Surface Antibody Date:</strong></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Dose 2:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dose 3:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hep B Surface Antibody Date:</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Booster*: ___/___/___ *after repeating the HepB series or Booster, the requirement has been met*

<table>
<thead>
<tr>
<th><strong>Last TB skin test</strong> (PPD/Mantoux): (May never be more than one year old during matriculation)</th>
<th><strong>TB Skin Test Date:</strong></th>
<th><strong>Result:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If PPD is positive, chest x-ray is required. After submitting a normal chest x-ray at entry, an annual note from your health care provider that you are symptom free or a repeated normal chest x-ray will satisfy the yearly test required.</strong></td>
<td><strong>X-Ray Date:</strong></td>
<td><strong>Result:</strong></td>
</tr>
<tr>
<td><strong>X-Ray Date:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Date of Vaccine:</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Influenza Vaccine:</strong> (Required Annually).</th>
<th><strong>Date of Vaccine:</strong></th>
<th></th>
</tr>
</thead>
</table>

*Primary Care Provider Signature AND Provider’s stamp is required for immunizations on this form to be accepted.*

_____________________________ Date: ________________

**Provider's Signature**

Provider Name (printed): ________________________________

Phone Number: (___)______________________________

Name of Clinic: ________________________________

Address: ________________________________

City, State, ZIP: ________________________________

Place Provider’s Stamp Here
LAMAR UNIVERSITY
COLLEGE OF ARTS AND SCIENCES
JOANNE GAY DISHMAN SCHOOL OF NURSING
PRACTICUM READINESS DOCUMENTS

Students: Be sure to sign the immunization release statement below.

IMMUNIZATION RELEASE STATEMENT

I have reviewed this immunization history for completeness and agree to release the information provided on the Lamar University Practicum Readiness Documents to authorized members of Lamar University Department of Nursing staff and authorizes staff of cooperating agencies, as may be required.

Print student name: ____________________________  Date of Birth: ____________________________

Student Signature: ____________________________  Date: ____________________________

Lamar University works with Student Check/Sentry MD, a confidential health information service. Student Check/Sentry MD maintains and processes all student immunization records and monitors compliance with state law requirements. The information may be provided to authorize members of Lamar University Department of Nursing and authorized staff of cooperating agencies as may be required.
LAMAR UNIVERSITY
COLLEGE OF ARTS AND SCIENCES
JOANNE GAY DISHMAN SCHOOL OF NURSING
PRACTICUM READINESS DOCUMENTS

Part III: Physical Examination

NAME ___________________________ L# ________________________ DOB ________________

Students in the Lamar University Nursing Program must be in a state of health that will allow them to participate in all practicum phases of the program of study in a manner that will not jeopardize the health or safety of clients or themselves. The following items are to assist in determining this requirement.

INSTRUCTIONS:
• Have Health Care Provider complete this form. Only this form or the Physical Exam completed at the Lamar University Student Health Center will be accepted.
• Submit completed form by emailing it to lamar@sentrymd.com or upload it directly to the Sentry MD Secure Uploader as a PDF attachment (go to http://mysentrymd.com/sentrymd.html#/upload/26).
• Retain a copy of the completed form for your files

If the results are outside normal limits the student will be counseled by the program director regarding any implications that the results may have for completion of program requirements.

VISION:
RIGHT vision (corrected) _______________ LEFT vision (corrected) _______________

HEARING:
Hearing Deficit RIGHT: ☐ No ☐ Yes Hearing Deficit LEFT: ☐ No ☐ Yes

LIFTING:
Ability to lift 50 pounds and turn heavy objects: Unlimited? : ☐ No ☐ Yes
If no, provide written documentation from Primary Care Physician of limitations.

LIMITATIONS:
Are there any practicum situations, because of mental or physical limitations, this individual should not be assigned to: ☐ No ☐ Yes If yes, please explain______________________________

CHRONIC CONDITIONS:
Does this individual have any chronic health problems: ☐ No ☐ Yes If yes, please explain_____________________________

If yes, are these problems under appropriate medical supervision?___________________________

Please indicate any specific health conditions that faculty in the nursing program need to be aware of. ☐ None ☐ Condition: _________________________________
Please explain: _________________________________

Signature: ______________________________________ Date: __________________________
Printed Name:____________________________________ Title: _______________________
Phone Number: ____________________________________
Name of Clinic:____________________________________ Address: ______________________
City, State, ZIP: __________________________________
LAMAR UNIVERSITY
COLLEGE OF ARTS AND SCIENCES
JOANNE GAY DISHMAN SCHOOL OF NURSING
PRACTICUM READINESS DOCUMENTS

Student Checklist

☐ Submit the information requested in Parts I & II regarding immunizations, dates of titers/vaccines and results to Sentry MD. Be sure that it has been signed by your Health Care Provider. (Remember: Sentry MD will accept separate documentation of the individual requirements provided that they are on a healthcare facility form, dated and signed.)

☐ You must sign and submit the Immunization Release Statement to Sentry MD

☐ Submit the physical exam form in Part III, which has been completed and signed by your Health Care Provider to Sentry MD. (OR - you may submit a copy of the completed physical exam form from the Lamar University Student Health Center.)

☐ Submit a copy of the following documentation to Sentry MD:
  o Lamar University receipt for payment of Professional Liability Insurance, and
  o American Heart Association CPR Certification card.

All of the above requirements are to be submitted to Student Check/Sentry MD by August 18, 2017.

Submit documents:

1) By attaching PDF to email: lamar@sentrymd.com

   -or-

2) By uploading directly to the Sentry MD Secure Uploader as a PDF attachment (go to http://mysentrymd.com/sentrymd.html#/upload/26)

Questions: Please email Student Check/Sentry MD at lamar@sentrymd.com or, visit our website at www.sentrymd.com.