

**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.*

<b>Name: (Please Print)</b>	
Last                      First                      MI	<b>Lamar University Email Address</b>
<b>Date of Birth:</b> ____/____/____	<b>Secondary Email Address</b>
<b>Phone:</b> (____) _____ - _____	
<b>Street Address</b>	
<b>City, State, Zip</b>	

**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.

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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.

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**Students must submit required immunization forms and Practicum Readiness Documents by email to: [lamar@sentrymd.com](mailto:lamar@sentrymd.com) –or– upload it directly to the Sentry MD Secure Uploader as a PDF attachment (go to <https://upload.sentrymd.com/>)**

**The deadline to submit these forms is January 6, 2017.**

**Please remember it may take up to 3 days to process your documents, so please plan your submission accordingly.**

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**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 completed form by emailing it to [lamar@sentrymd.com](mailto:lamar@sentrymd.com) **-or-** **upload** it directly to the Sentry MD Secure Uploader as a PDF attachment (go to <https://upload.sentrymd.com/>)

**→ KEEP A COPY FOR YOUR OWN RECORDS. ←**

**Forms are due by January 6, 2017**

<b>Polio:</b> Proof of initial series OR Exempt by age	<b>Vaccine Dates:</b> <b>Dose 1:</b> ___/___/___ <b>Dose 2:</b> ___/___/___ <b>Dose 3:</b> ___/___/___ <b>Dose 4:</b> ___/___/___		
<b>Measles, Mumps and Rubella (MMR):</b> Documentation of two doses of vaccine <b>or</b> confirmed immunity by serology <b>or</b> written waiver or letter from primary care provider stating medical reason for exemption.	Dates (Required): <b>Dose 1</b> Measles: (Rubeola): ___/___/___  Mumps: ___/___/___  Rubella: ___/___/___	Dates (Required): <b>Dose 2</b> Measles: (Rubeola): ___/___/___  Mumps: ___/___/___  Rubella: ___/___/___	<b>Results of MMR Titters (Required):</b>  Immune___ Non-immune___  Immune___ Non-immune___  Immune___ Non-immune___
<b>Tetanus Diphtheria, Pertussis and Tdap:</b>	<b>DPT or DTaP - Date of Series</b> <b>Dose 1:</b> ___/___/___ <b>Dose 2:</b> ___/___/___	<b>Tdap Booster*:</b> ___/___/___ *if more than 10 yrs. old, then Td booster is required.	<b>Td Booster (no more than 10 yrs. old)</b> ___/___/___
<b>Varicella:</b> Dates of 2 immunizations <b>or</b> confirmed immunity by serology <b>or</b> confirmation of the disease from healthcare provider or official school records <b>or</b> written waiver or letter from primary care provider stating medical reason for exemption	<b>Vaccine 1:</b> ___/___/___  <b>Varicella 2:</b> ___/___/___	<b>Date of Serology (Titer):</b> ___/___/___  Immune ___ Non-immune ___	<b>Written waiver or letter:</b> ___/___/___

<p><b>Hepatitis B:</b> Dates of 3 immunizations (primary series) <u>and</u> Laboratory confirmed immunity by serologic testing (if the serologic testing is negative immunity, then the student must</p> <ul style="list-style-type: none"> <li>•take one booster or repeat a 2<sup>nd</sup> series [3 immunizations]</li> <li>•after repeating the Hep B series or booster, the requirement has been met) <b>or</b> confirmed immunity by serologic testing <b>or</b> written waiver or letter from primary care provider stating medical reason for exemption</li> </ul>	<p><b>Dose 1:</b> ____/____/____</p> <p><b>Dose 2:</b> ____/____/____</p> <p><b>Dose 3:</b> ____/____/____</p>	<p><b>Hep B Surface Antibody Date:</b> ____/____/____</p> <p>Immune _____ Non-immune _____</p>	<p><b>Booster*:</b> ____/____/____ *after repeating the HepB series or Booster, the requirement has been met</p>
<p><b>Last TB skin test</b> (PPD/Mantoux): (May never be more than one year old during matriculation)</p> <p>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.</p>	<p><b>TB Skin Test Date:</b> ____/____/____</p> <p><b>X-Ray Date:</b> ____/____/____</p>	<p><b>Result:</b> Neg____Pos____</p> <p><b>Result:</b> Neg____Pos____</p>	
<p><b>Influenza Vaccine:</b> (Required Annually). <b>2016-17 Influenza Vaccine due by: 01/06/17</b></p>	<p><b>Date of Vaccine:</b> ____/____/____</p>		

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

\_\_\_\_\_  
*Provider's Signature*

Date: \_\_\_\_\_

Provider Name (printed): \_\_\_\_\_

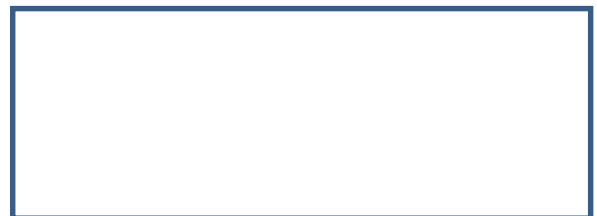
Phone Number: (\_\_\_\_) \_\_\_\_\_

Name of Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

*Place Provider's Stamp Here*



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**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.

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**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](mailto:lamar@sentrymd.com) **-or- upload** it directly to the Sentry MD Secure Uploader as a PDF attachment (go to <https://upload.sentrymd.com/>)
- 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: \_\_\_\_\_

*Place Provider's Stamp Here*

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**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:
  - Lamar University receipt for payment of Bill Beatty Professional Liability Insurance, and
  - American Heart Association CPR Certification card.

**All of the above requirements are to be submitted to  
Student Check/Sentry MD by January 6, 2017.**

Submit documents:

1) By attaching PDF to email: [lamar@sentrymd.com](mailto:lamar@sentrymd.com)

**-or-**

**2) By uploading directly to the Sentry MD Secure Uploader as a PDF attachment (go to <https://upload.sentrymd.com/>)**

Questions: Please email Student Check/Sentry MD at [lamar@sentrymd.com](mailto:lamar@sentrymd.com) or, call 1-800-633-4345 or, visit our website at [www.sentrymd.com](http://www.sentrymd.com).