California State University Los Angeles – School of Nursing
Student Information and Health Clearance Form

Upload this form along with required attachments to https://mycb.castlebranch.com/ (see package code below). Information must be updated yearly or when current expiration dates are reached. Keep the originals of this form and all documents in your possession throughout the school year. You may be asked by clinical sites and/or faculty to present your documents. Not completing all health clearance items for the SON and for the clinical site may prevent you from successfully completing course requirements.

General Information

Check One ☑	☐	☐	☐	☐	☐
PROGRAMS	BSN Basic	RN to BSN	MSN & Post Masters	ABSN	ADN Collaborative
CODE	CQ83bsn	CQ84rnbsn	CQ85ms	CQ85absn	LH11adnbsn

Student Full Name _____ CIN _____

Student Telephone # _____ Student Email _____

Address _____ City _____ Zip Code _____

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone # _____

REQUIRED DOCUMENTATION (provide copies of all, for cards, front and back w/signature)		**frequency: ☑**
American Heart Association CPR (BLS) Cert. (Health Care Provider: 2yrs)		Every 2 yrs ☐
California Driver License		**once & when renewed** ☐
Auto Liability Insurance	Students name must appear on policy	**once & when renewed** ☐
RN License *(absn/bsn basic exempt)*		**once & when renewed** ☐
Health Insurance	Students name must appear on card	**once & when renewed** ☐
University Liability Insurance	Coverage July 1st through June 30th (available for purchase July 1st of every year)	yearly ☐
HIPAA certificate *(Take quiz, print certificate and upload to casltebranch)*	Date: _____ https://www.csudh.edu/son/info/hipaa-precautions/hipaa-quiz OR for BSN: ATI skills module	yearly ☐
Background Check *(included with castlebranch purchase)*	Purchase Date: ___	once ☐
Live Scan (if required by clinical site)	Date: _____	once ☐
Drug Screening (UGRD only - GRADS, if required by clinical site)	Date: _____	yearly ☐
Fire Card (UGRD only - GRADS, if required by clinical site)	Date: _____	**once & when renewed** ☐

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REQUIRED HEALTH SCREENING (Immunizations): Copies of all required (results should include lab values with immunity status)		**frequency: ☑**
MMR or Positive Titers ____Measles(Rubeola) _____Mumps _____Rubella	Date: #1 _____ Date: #2 _____ Date: #3 _____	once ☐
Varicella (Chicken Pox) or Positive Titer (_____)	Date: #1 _____ Date: #2 _____	once ☐
___Hep B Series or___Declination or ___Positive Titer	Date: #1 _____ Date: #2 _____ Date: #3 _____	once ☐
Tdap	Date: _____	once ☐
___Influenza (Flu) Vaccination or ___Declination	Date: _____	yearly ☐
Physical Exam (see pg 3)		yearly ☐

Please submit documentation of a current 2 step TB skin test or a past 2 step TB skin test along with a current 1 step TB or X-ray or QuantiFERON Gold Blood test. The renewal date will be set for 1 year. Upon renewal, one of the following is required: 1 step TB Skin test OR QuantiFERON Gold Blood test OR Chest X-Ray (if positive TB).

TB 2-step (once to be followed by yearly 1 step, X-ray or QuantiFERON) Date: _____ Result: _____	Date: #1 _____Date: #2 _____ (one to three weeks apart)	once ☐
TB test date Last 12 months: _____ Result: _____ **OR**		yearly ☐
*Positive TB provide a negative Chest X-Ray report **OR** Chest X-Ray Date: _____ Result: _____		yearly ☐
QuantiFERON Gold Blood test: Date: _____ Result: _____		yearly ☐

First 2 pages of this document must be completed and uploaded to castlebranch under the "Medical History" requirement.

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Physical Exam:

_____ was examined on the below date and I found her/him to be in satisfactory health and able to participate fully in the School of Nursing academic program.

_____
Signature of Clinician *

_____
Printed Name

_____
Date

*This health examination is to be done by a physician, nurse practitioner, or physician's assistant.

MD/DO _____ NP _____ PA _____

Agency: _____

Clinician Comments: