Health Requirements for Beal University
Nursing Program

Dear Beal University Student,

Congratulations on your acceptance to Beal University! We know you are excited to embark on your medical education. Before you can get started, there are some important and mandatory health requirements that MUST be completed before you will be allowed to start your classes. Beal University has contracted with Sentry MD to store and maintain their student health forms. Sentry MD is a confidential student health record service.

Included in this packet are the health and immunization requirements that are required of you to participate in the Beal University Nursing program. It is important that you review this material carefully and upload them as **ONE PDF** to the Secure Student Uploader link at https://mysentrymd.com/sentrymd.html#/upload/49.

Upon receipt of your health forms, Sentry MD will be notifying Beal University of your compliance status. To verify receipt of your records or to ask any questions please email us at Beal@SentryMD.com. Failure to provide complete health and immunization documents ***may delay your entry or ability to participate*** in the programs required for your study.

To become compliant with Beal University, you will need to follow the steps below.

STEP 1: Purchase the Health Record Management Tracking Service

- Go to www.mystudentcheck.com and select 'Beal University Nursing – Immunization Tracking' from the 'School' dropdown menu.
- Select your program from the 'Program' dropdown menu. Click 'Submit' Complete all required fields as prompted and enter your payment information.
- This will complete your account registration for the health requirement tracking and background check.

STEP 2: Review the following pages which list all current requirements to comply with Beal University

- Part I Student Information- Student to complete
- Part II Student Consent Statement- Authorization for Sentry MD to provide Beal University with information regarding your immunizations. This must be signed by the Student.
- Part III Submit a copy of CPR and health insurance cards.
- Part IV Health Requirements- One page is to be completed by a health care provider. There are specific instructions on this form for each immunization, titer or test requirement.
- Part V Student Health History- Student to complete
- Part VI Physical Exam- to be completed by healthcare provider
- Part VII Account Access- Sentry MD student account access instructions on how to login to your account in order to always stay on top of your requirements.

STEP 3: Submit Documents

- Submit all requirements to https://mysentrymd.com/sentrymd.html#/upload/49 or as a PDF attachment via email to Beal@Sentrymd.com.

In addition to storing the required information, Sentry MD will keep Beal University informed throughout your term of study of your compliance status with the requirements. Students are responsible for maintaining their compliance throughout the program and must submit any updates to the Secure Student Uploader at https://mysentrymd.com/sentrymd.html#/upload/49.

If you have any questions regarding this packet, please email us at Beal@SentryMD.com.

Sincerely,

Sentry MD Customer Service

Health Requirements for Beal University
Nursing Program

PART I STUDENT INFORMATION | *this must be completed by the Student.*

Last Name:	**First Name:**
DOB: _____/___/_____	**Cell Phone:**
Student ID #:	**Email Address:**

PART II STUDENT CONSENT STATEMENT | *This must be completed by the Student.*

I have reviewed this immunization history for completeness and agree to release the information provided on the Beal Immunization Transcript and all documents submitted to Sentry MD to authorized members of the Beal University staff and staff of cooperating agencies, as may be required. I understand that Beal University is a drug-free campus.

_____ _____
Student Signature Date of Birth

_____ _____
Student Name (Print) Date

PART III ADDITIONAL DOCUMENTS TO SUBMIT | *This must be completed by the Student.*

- **BLS for HealthCare Provider CPR**: Submit a copy of your CPR card. **ONLY** the Basic Life Support (BLS) for Healthcare Provider course through American Heart Association is accepted.
- **Health Insurance**: Submit a copy of your Health insurance card (Front and Back).

Health Requirements for Beal University
Nursing Program

PART IV HEALTH REQUIREMENTS | *This must be completed by your health care provider with signature and stamp **OR** left blank and used as a guideline if you provide supplemental documentation from the clinic or Doctor you received the below requirements from.*

LAST NAME:	**FIRST NAME:**	**DOB:**

Measles (Rubeola), Mumps, and Rubella (MMR): Two Vaccine series if born after 1957 **OR** Serologic proof of immunity by titer for Measles (Rubeola), Mumps, and Rubella. *If titer is nonreactive (negative or equivocal), MMR booster required after titer date.

MMR Vaccine 1 Date: ___/___/___ **MMR Vaccine 2 Date:** ___/___/___ **OR**	**Measles Titer Date:** ___/___/___ **Result: ☐Immune ☐ Non-Immune** **Mumps Titer Date:** ___/___/___ **Result: ☐ Immune ☐ Non-Immune** **Rubella Titer Date:** ___/___/___ **Result: ☐ Immune ☐ Non-Immune**	**MMR Booster Date:** ___/___/___ **If Non-immune titer*

Hepatitis B: Three Vaccine doses at 0 month, 1 month and 6 month **AND** Serologic proof of immunity by titer for Hepatitis B.
*If titer is nonreactive (negative or equivocal), HepB booster required and repeat titer 6 weeks later.

HepB Vaccine 1 Date: ___/___/___ **HepB Vaccine 2 Date:** ___/___/___ **AND** **HepB Vaccine 3 Date:** ___/___/___	**HepB Titer Date:** ___/___/___ **Result: ☐Immune ☐ Non-immune**	**If Non-immune titer* **HepB Booster Date:** ___/___/___ **Submit copy of repeat titer 6 weeks from booster date.**

Varicella: Two Vaccine series **OR** Serologic proof of immunity by titer for Varicella.
*If titer is nonreactive (negative or equivocal), Varicella booster required after titer date.

Varicella Vaccine 1 Date: ___/___/___ **Varicella Vaccine 2 Date:** ___/___/___ **OR**	**Varicella Titer Date:** ___/___/___ **Result: ☐Immune ☐ Non-Immune**	**Varicella Booster Date:** ___/___/___ **If Non-immune titer*

Tetanus Diphtheria, Pertussis (Tdap): Tdap required every ten years, TD accepted after initial Tdap on file.

Tdap Vaccine Date: ___/___/___	**TD Booster Date (ONLY if Tdap is on file):** ___/___/___

Influenza Vaccine (Flu): Required seasonally.

Influenza Vaccine Date: ___/___/___

Tuberculosis Two-Step (PPD/Mantoux): Two TB skin tests are required and must be no more than 21 days apart with a negative result and within 12 months of the current date **OR** TB Blood Draw (T-Spot or QunatiFERON TB Gold test within a year with a negative result).
Annual update required.
If a TB skin test is positive, a chest x-ray must be completed and **updated every two years.*

PPD Test 1 Date Placed: ___/___/___ **PPD Test 1 Date Read:** ___/___/___ **Lot #:**_____ **Reading __mm ☐ Negative ☐ Positive** **PPD Test 2 Date Placed:** ___/___/___ **PPD Test 2 Date Read:** ___/___/___ **Lot #:**_____**Reading __mm ☐ Negative ☐ Positive**	**TB QuantiFERON gold Date:** ___/___/___ **Result: ☐ Negative ☐ Positive** **T-Spot Test Date:** ___/___/___ **Result: ☐ Negative ☐ Positive**	**Chest X-Ray Date:** ___/___/___ **Result: ☐ Negative ☐ Positive**

In cases of sincere religious belief or for moral, philosophical or other personal reasons, a student may submit a statement in writing of their opposition to immunization. Medical exemptions and other written oppositions must be accompanied by a signed letter of opposition form available. Email Beal@SentryMD.com to request letter of opposition.

Healthcare Provider Signature AND/OR Provider's stamp is required for immunizations on this form to be accepted.

Provider' Signature: _____ **Date**_____

Provider Name (Printed): _____

Phone Number: (___) ___-_____

PLACE PROVIDER'S STAMP HERE

PART V STUDENT HEALTH HISTORY| *To be complete by the student and reviewed by the Physician who is completing your Physical Exam on the following page.*

Last Name: _____First Name: _____Date of Birth: _____

Gender: ☐ Male ☐ Female

Have you ever had, or do you now have any of the following?

1. Arthritis ☐ Yes ☐ No
2. Asthma ☐ Yes ☐ No
3. Chicken Pox ☐ Yes ☐ No
4. Convulsions/Seizures ☐ Yes ☐ No
5. Diabetes ☐ Yes ☐ No
6. Heart problems ☐ Yes ☐ No
7. Hemophilia / bleeding ☐ Yes ☐ No
8. Hepatitis A, B or C ☐ Yes ☐ No
9. Hypertension ☐ Yes ☐ No
10. Tuberculosis ☐ Yes ☐ No
11. Other ☐ Yes ☐ No

If you answered "Yes" to any of the previous, please provide details:
_____

Do you have any allergies? ☐ Yes ☐ No
If yes, please specify: _____

Are you taking any prescribed medicine(s)? ☐ Yes ☐ No
If yes, please specify: _____

Do you have any physical, emotional or psychological conditions that would prevent you from performing the essential functions of a Nurse? ☐ Yes ☐ No
If yes, please specify: _____

Other comments about your general health and physical condition: _____
_____

Student's Signature: _____
Date: _____

Health Requirements for Beal University
Nursing Program

PART VI PHYSICAL EXAM | *This must be completed by your health care provider with signature and stamp. Only required upon entry into the program.*

Last Name: _____ First Name: _____ Date of Birth: _____

Height: _____ Blood Pressure: _____
Weight: _____ Pulse: _____
Vision:

Right 20/ corr. to 20/

Left 20/ corr. To 20/

***Clinical Evaluation*:** Using the following checklist, please indicate any abnormality that might prohibit the student from performing the essential functions of a Nurse.

	Normal	Abnormal	Comment
1. Head, neck, face, scalp	☐	☐	_____
2. Eyes (external exam; fund)	☐	☐	_____
3. Pupils & ocular motion	☐	☐	_____
4. Ears – canals, drums	☐	☐	_____
5. Hearing - right	☐	☐	_____
6. Hearing - left	☐	☐	_____
7. Nose, sinuses	☐	☐	_____
8. Throat, mouth	☐	☐	_____
9. Teeth	☐	☐	_____
10. Lungs, thorax-breasts	☐	☐	_____
11. Heart	☐	☐	_____
12. Vascular system	☐	☐	_____
13. Abdomen – include hernia	☐	☐	_____
14. Genitourinary system	☐	☐	_____
15. Endocrine system	☐	☐	_____
16. Spine	☐	☐	_____
17. Upper extremities	☐	☐	_____
18. Lower extremities	☐	☐	_____
19. Feet	☐	☐	_____
20. Skin, lymphatics	☐	☐	_____
21. Neurologic, psychologic	☐	☐	_____

Is this student free from communicable diseases? ☐ Yes ☐ No

Is this student under treatment for any physical, emotional or psychological problems? ☐ Yes ☐ No
If "yes" please specify: _____

Is this student on any regular medication therapy? ☐ Yes ☐ No
If "yes" please specify: _____

Are there any restrictions regarding the student's participation in the clinical or physical areas of the Nursing program? ☐ Yes ☐ No
If "yes" please specify: _____

Healthcare Provider Signature AND/OR Provider's stamp is required for immunizations on this form to be accepted.

Provider' Signature: _____ **Date** _____

Provider Name (Printed): _____

Phone Number: (___) ___-_____

PLACE PROVIDER'S STAMP HERE

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Nursing Program

Student Checklist:

Student Information is complete (Part I)

Authorization Consent form is signed by Student (Part II)

Submit a copy of your BLS for Healthcare Provider CPR certification (Part III)

Submit a copy of your health insurance card, *front and back* (Part III)

Health Requirements in Part III are complete, and results are signed, dated and stamped by your Health Care Provider OR you have obtained supplemental documentation to meet each requirement (Part IV)

Health History is completed and signed by student (Part V)

Physical Exam has been completed by Healthcare Provider (Part VI)

Account Access below has been reviewed by the student and you are able to login and see your compliance status after you have purchased the Student Check tracking and submitted your documents for review (Part VII)

All of the above documents are to be submitted to Sentry MD.
Return your completed forms by uploading them as **ONE PDF** to the Secure Student Uploader at https://mysentrymd.com/sentrymd.html#/upload/49.

Please email any questions you may have to Beal@SentryMD.com

PART V- ACCOUNT ACCESS

Please note your account will only be available after you have registered and sent Part I of this packet into Sentry MD. Your account allows you to see your status and download/print documents that have been processed by Sentry MD. Please make sure to submit document requirements to the Upload link https://mysentrymd.com/sentrymd.html#/upload/49 or to Beal@SentryMD.com as you are not able to upload directly to your account, all documents are reviewed and processed prior to showing in your account *(Processing can take 24 to 48 hours).*

Link to Sentry MD system:
https://mysentrymd.com/sentrymd.html#/home

1. Enter your User ID: (email address you registered with in all lowercase)
2. Click on Set Password
3. Enter your email address (your User ID will be the email address you registered with in all lowercase)
4. You will be sent a token to your email address
5. Enter Token from email onto site
6. Create a Password
7. Click link to go to login screen.

Once you are logged into your account, you will note on the landing page how easy it is to see if you are compliant or not with the requirements for your program. A blue checkmark next to each of the requirements means you are compliant. Requirements without the blue checkmark indicate you are missing documentation these items need your attention.

In addition to viewing your status at any time, you can download and print your landing page checklist and any or all the documents you have submitted by clicking the Documents Button. Only documents that have completed processing will appear in your account, please note processing can take 48 business hours. We hope these tools help you stay on top of your status and keep you compliant with your program requirements.