BSN-PL, BSN-AT AND RN-BSN STUDENTS

All UMKC School of Nursing & Health Studies BSN students must provide written documentation of the following immunizations and/or tests to Verified Credentials, Inc. prior to enrollment. To upload your documents go to https://scholar.verifiedcredentials.com/umkc.

Required frequency = yearly, biennial (every 2 years), & one time requirement

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu Vaccine</td>
<td>Yearly</td>
</tr>
<tr>
<td>TB</td>
<td>2-Step TB skin tests or TB titer (T-Spot or Quantiferon-TB Gold) less than 12 months old. All positive reactors must visit their Health Department &amp; bring a copy of the Dept.’s documentation of this visit with their follow up plan to us. (Skin test or Quantiferon must be done yearly. If positive chest x-ray submitted once but if symptoms arise another x-ray will be required.)</td>
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<tr>
<td>RN license(s) from any state</td>
<td>Expiration</td>
</tr>
<tr>
<td>CPR</td>
<td>Expiration</td>
</tr>
<tr>
<td>MMR</td>
<td>Expiration</td>
</tr>
<tr>
<td>MMR Titer</td>
<td>Expiration / Titer</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Expiration</td>
</tr>
<tr>
<td>Hepatitis B Titer</td>
<td></td>
</tr>
<tr>
<td>Chicken Pox</td>
<td></td>
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</tbody>
</table>

5. MMR
   A. For students born prior to 1957, rubella titers are required
   B. For students born after 1956, measles, mumps, and rubella (MMR) immunity may be documented in the following ways:
      a) Documentation of two doses of MMR after age of twelve (12) months and rubella titer, OR
      b) Evidence of immunity through a titer, for example, Mumps IGG, Rubeola IGG (measles), Rubella IGG. Titers are preferable if immunizations are contraindicated (e.g. pregnancy)

6. Tdap - Tetanus/diphtheria/pertussis immunity via documentation of toxoid booster date within last 10 yrs.

7. Hepatitis B - Completion of Hepatitis B vaccine series and titer. If titer is negative, repeat series & titer.

8. Chicken Pox – Two varivax vaccinations at least 28 days apart or varicella IGG titer (w/positive reading)

I understand that I must maintain current records. Failure to comply with this policy by allowing immunizations to expire may have the following consequences. I may be restricted during enrollment and/or dropped from clinical courses. Evidence of inability to comply must be provided in writing from an appropriate authority in order to be exempt from the terms of this policy. The information I have submitted is accurate to the best of my knowledge. I will also keep copies of all of the above with me for clinical site verification.

PRINT NAME          DATE          SIGNED NAME

HIPAA - Contact your clinical site regarding their HIPAA certification details.
The Department of Mental Health for the State of Missouri has added a requirement for all students to now complete an additional background check through the Department of Health and Human Services. Students must register through the Family Care Safety Registry at: http://health.mo.gov/safety/fcsr/index.php

There is a $12.00 fee for the background check and a $1.25 processing fee. You will need your Social Security number and a credit card to pay for this service. When you go to register it will ask you to select worker type on the form. Your options are child care worker, elder care worker, personal care worker, recipient of state or federal funds, voluntary registrant or foster parent. Students are to mark voluntary registrant.

Once you have submitted your information on-line you are usually registered that same day and the background check is done immediately. A letter is then sent to you with verification of registration and the results.

You MUST upload a copy of this letter to VERIFIED CREDENTIALS. If you are already registered with them, please request they re-send the results.

Click on this link http://health.mo.gov/safety/fcsr/index.php then click here

Be sure to SELECT “Volunteer” when you get to the “Selection Criteria” screen:
Person is infected with *M. tuberculosis*

Person is skin tested

Person has negative reaction due to decreased ability to react to tuberculin
However, this skin test "jogs the memory" of the immune system to recognize and react to tuberculin

As years pass, person's ability to react to tuberculin lessens

Person is skin tested again

Up to 1 year later (for this example, we assume that the person was NOT exposed to TB during this time)

Person has a positive reaction. This is a boosted reaction due to TB infection that occurred a long time ago, not during the time between the two skin tests

**Two-Step Testing**

- Only conducted when TST is used

- Distinguishes between boosted reactions and reactions caused by recent infections

- Should be used for initial skin testing of persons who will be retested periodically

- If person's initial skin test is negative, they should be given a second test 1-3 weeks later
  - Second test positive: probably boosted reaction
  - Second test negative: considered uninfected
Figure 3.5  
Two-step testing

Baseline skin test

Reaction

Negative

Retest 1-3 weeks later

Positive

Person probably has TB infection

Reaction

Negative

Person probably does NOT have TB infection

Repeat at regular intervals; a positive reaction will probably be due to a recent TB infection

Positive

Reaction is considered a boosted reaction

Retesting not necessary

POSITIVE TUBERCULIN SKIN TEST FOLLOW-UP

The University of Missouri-Kansas City School of Nursing and Health Studies is required by the Occupational Safety and Health Administration (OSHA) to evaluate all student nurses for tuberculosis on an annual basis. If you have had a positive reaction, please complete the following information and sign the form. Then take this form to local Health Department for their evaluation & recommendations for follow-up. Bring back copy of this form and their evaluation/recommendations to us for your student file.

Previous known TB exposure?  Yes ☐ No ☐
  If yes, relationship ________________________________
    (eg. Spouse, parent, child, etc.)

Have you taken medication for TB Therapy or Prevention of TB? Yes ☐ No ☐
  Dates __________________________

Date of last Chest X-ray _________________
  Where Chest X-ray performed ____________________________
  Results __________________________(Neg or Pos)

Have you ever received the “BCG” Vaccine? Yes ☐ No ☐
  If yes, what country ____________________________
  How old were you when you received the vaccine? _________________

Have you experienced any of the following signs or symptoms in the past three months? Yes ☐ No ☐
  Fever with unknown cause
  Loss of appetite
  Unexplained weight loss
  Malaise? (vague feeling of physical discomfort or uneasiness)
  Chronic cough – unexplained for more than two weeks
  Sputum (Do you cough or spit up anything?)
    Yes ☐ No ☐ Is there blood in the sputum?
    Yes ☐ No ☐ Is the blood brown in color?
  Chest pain?
  Night sweats?

________________________________________  ____________________________________
Student signature and date                RN signature and date