

UMFK Nursing Students
Immunization & Health Evaluation Form

This form must be completed by **all students enrolled in the Nursing program**. Please forward to your physician, nurse practitioner, school nurse or a health official for proper dates and necessary signature. The Maine College System and Maine State Law require that the following be completed.

Dear Health Care Provider:

Your patient is enrolled in the Nursing Program at the University of Maine at Fort Kent. Please assist us in this effort by documenting the immunization status of this student. This is a nursing program requirement.

IMMUNIZATION DATA WILL ONLY BE ACCEPTED ON THIS FORM

Student's Name _____ Date of birth _____

STUDENTS MUST HAVE:

1. Diphtheria-Tetanus Booster within the last 10 years. _____
Date

MMR (Mumps, Measles and Rubella) two (2) dose of vaccine or date of immune titer (REQUIRED)

1 st Vaccine	Date	2 nd Vaccine	Date
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OR:

- | | | |
|-----------------------------------|------|---------|
| 1. Measles (Rubeola) Immune Titer | Date | Results |
| 2. Rubella Immune Titer | Date | Results |
| 3. Mumps Immune Titer | Date | Results |

Lab test verifying immunity must be provided

2. Hepatitis B Series

Injection 1 _____	Injection 2 _____	Injection 3 _____
Date	Date	Date

Titer (<i>required after series</i>)	Titer Results	Date
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Lab test verifying immunity must be provided

3. Varicella Titer _____

Lab test verifying immunity must be provided Date _____ Results _____

If titer negative (not immune) 2 doses of varivax vaccination is required

Varivax 1 _____	Varivax 2 _____
Date	Date

4. Tuberculin Test (PPD) within 1 month of enrollment and **annually while in school.**

Type _____	Date Administered _____	Signature _____
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Date Read _____	Results _____	Signature _____
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Students may be exempt from immunization requirements with a health care professional's written statement that the vaccine is inadvisable at this time.

 Signature of Physician / Health Care Professional

 Print Physician / Health Care Professional Name

 Telephone #

 Print Physician / Health Care Professional Address

Required Physical Examination

Name: _____ Age: _____ Sex: _____

GENERAL: _____ Height: _____ Weight: _____

Vital Signs: Temp _____ Pulse _____ Resp. _____ BP _____

Skin: _____

Head: _____

Eyes: Pupils _____ E.O.M.'s _____ Conjunctiva _____ Sclera _____

Fundi _____ Vision R _____ L _____ s/c glasses _____

Ears: _____ Nose: _____

Pharynx: _____ Teeth: _____

Neck: _____ Thyroid: _____

Lymphadenopathy: _____

Back: _____ CVA Tenderness _____

Lungs: _____

Breasts: _____

CV: S-1 _____ S-2 _____ Murmurs _____

Pulses: Carotid Radial Femoral Dorsal Pedis Post Tibial

Right _____

Left _____

Abdomen: _____ Hernia _____

Neuro: Motor _____ Sensory _____

CN _____ Reflexes _____

Mental Status _____

Ms: Deformities _____

Edema _____ Varicosities _____

Genital: Female _____ Male _____

Laboratory: (Required)

Urine: Glucose _____ Protein _____ Ph _____ Blood _____

CBC: Hgb _____ Hct _____ WBC _____ Platelet _____ Lymph _____

Impression: _____

Examiner: _____

Date: _____

Return to: Division of Nursing
University of Maine at Fort Kent
23 University Drive
Fort Kent, ME 04743