

**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

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Student's Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Social Security # \_\_\_\_\_

**STUDENTS MUST HAVE:**

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

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

1<sup>st</sup> Vaccine \_\_\_\_\_ Date \_\_\_\_\_ 2<sup>nd</sup> Vaccine \_\_\_\_\_ Date \_\_\_\_\_

**OR:**

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

3. Hepatitis B Series (*must be started before starting classes*).  
Injection 1 \_\_\_\_\_ Injection 2 \_\_\_\_\_ Injection 3 \_\_\_\_\_  
Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_  
Titer (*required after series*) \_\_\_\_\_ Titer Results \_\_\_\_\_  
Date \_\_\_\_\_ Results \_\_\_\_\_

4. Varicella Titer \_\_\_\_\_  
Date \_\_\_\_\_ Results \_\_\_\_\_

If titer negative (not immune) 2 doses of varivax vaccination is required  
Varivax 1 \_\_\_\_\_ Varivax 2 \_\_\_\_\_  
Date \_\_\_\_\_ Date \_\_\_\_\_

5. Tuberculin Test (PPD) within 3 months of enrollment and annually while in school.  
Type \_\_\_\_\_ Date Administered \_\_\_\_\_ Signature \_\_\_\_\_  
Date Read \_\_\_\_\_ Results \_\_\_\_\_ Signature \_\_\_\_\_

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