UNIVERSITY OF NEW MEXICO-GALLUP
NURSING STUDENT HEALTH EXAMINATION FORM

Student Name _____

Primary Provider Health Examination Clearance

Dear Provider: Please select Yes or No for each statement related to the student's current health status. For any No response, please provide a comment or rationale.

☐ Yes ☐ No	I believe that this student is capable of safely lifting 50 pounds. If No, please write your comments below:
☐ Yes ☐ No	I have found no infectious disease at this time, or any condition that appears to prevent her/him from performing the duties of a student in the nursing program. If No, please write your comments below:
☐ Yes ☐ No	I have found no condition which might represent a possible hazard to the health of the student, patients, other students, or employees of any agency. If No, please write your comments below:

Additional comments that are not covered above:

_____

_____

_____

Provider signature _____ Date _____

Provider printed name _____

Provider address _____ Phone _____

Any change in the student's health status after this date must be reported to the nursing program.

Student name: _____

TB testing results and Immunizations

<table>
<tr><th colspan="5">TB Testing</th></tr>
<tr><td rowspan="2">Baseline PPD (2-Step) or IGRA blood test</td><td colspan="2">PPD #1 Date & Result:</td><td colspan="2">PPD # 2 Date & Result:</td></tr>
<tr><td colspan="4">IGRA Blood test date & result:</td></tr>
<tr><th colspan="5">Immunizations</th></tr>
<tr><td colspan="5">TdaP (Every 10 years) date:</td></tr>
<tr><td>MMR #1 Date:</td><td colspan="2">MMR #2 Date:</td><td colspan="2">MMR Titer date & result:</td></tr>
<tr><td>**Varicella #1 Date:</td><td colspan="2">Varicella #2 Date:</td><td colspan="2">Varicella titer date & result:</td></tr>
<tr><td>Influenza immunization Date:</td><td>***COVID-19 vaccine (also please indicate the vaccine product name or manufacturer)</td><td>Dose 1 date:
Clinic location:

Dose 2 date:
Clinic location:

Dose 3 date:
Clinic location:

Dose 4 date:
Clinic location:

Dose 5 date:
Clinic location:

Dose 6 date:
Clinic location:</td><td>Product name:

Product name:

Product name:

Product name:

Product name:

Product name:</td></tr>
<tr><td>Hepatitis B #1 Date:</td><td colspan="2">Hepatitis B #2 Date:</td><td colspan="2">Hepatitis B #3 Date:</td></tr>
<tr><td>Hepatitis B Titer result:</td><td>Date:</td><td colspan="3">Hepatitis B vaccine waived Date</td></tr>
</table>

If a student is not fully immunized for a disease, a titer must be provided – **no exceptions**.

**Vaccination or a titer is required to sufficiently prove varicella immunity. Documented history of varicella is insufficient proof.

*** COVID-19 vaccination requirements fluctuate depending on mandates from the Department of Health, UNM and clinical facility policies, or other entities. Please document COVID-19 vaccination series or doses if it has been acquired.