UNIVERSITY OF CENTRAL FLORIDA

COLLEGE OF NURSING HEALTH FORM

Phone: 407.823.2744 Website: https://nursing.ucf.edu/

Prior to your first semester at the UCF College of Nursing, you must have met the following heath requirements, as attested to by a licensed healthcare provider. This form and any other supporting documents must be uploaded into Castle Branch for verification. Please note: your TB test and physical exam are to be updated and submitted annually. Please upload the Health Form to Castle Branch and Student Health Services.

Name: _____ **UCF/PID:** _____ **Date**: _____

Program: ❒MSN ❒DNP ❒CERTS

REQUIRED IMMUNIZATIONS:

Tetanus/Diphtheria/Pertussis (Tdap) *Booster within the past ten years*	*Date* _____			
Measles, Mumps, Rubella (MMR) vaccine(s) OR laboratory evidence of a positive titer	*Dose 1* _____	*Dose 2* _____	*OR*	*Titer* _____
Varicella (Chicken Pox) Vaccine(s) OR laboratory evidence of a positive titer	*Dose 1* _____	*Dose 2* _____	*OR*	*Titer* _____
Hepatitis B Vaccine (at least two out of three must be completed prior to the start of clinical) OR laboratory evidence of a positive titer	*Dose 1* _____ *Titer* _____	*Dose 2* _____		*Dose 3* _____

HIGHLY RECOMMENDED:	*Date*	
Hepatitis A Vaccine	_____	
Meningococcal Conjugate Vaccine	_____	
Influenza Vaccine (annually)	_____	
COVID-19 Vaccine – 1 or series of 2 vaccines (depending on manufacturer)	_____	_____

Revised: 07.31.2024

HEALTH HISTORY & PHYSICAL EXAMINATION

TO BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER

Is there any significant medical history or condition that could affect functioning as a nursing student, including interaction with patients and staff in a clinical setting?
Yes ❒ No❒

Please Describe:

_____

_____

_____

Does this individual have a latex sensitivity?
Yes ❒ No ❒

Is this individual currently taking any medication that could affect participation in a nursing education program, including interaction with patients and staff in a clinical setting?
Yes ❒ No ❒

Please Describe:

_____

_____

_____

I certify that _____has been examined by me on _____and is found to be in good physical and mental health and appears able to undertake all aspects of the nursing education program, including interaction with patients and staff in a clinical setting. I also attest that the student has met all immunization requirements as reported in the previous page.

Provider's Name (PLEASE PRINT): _____Provider's Signature: _____

Licensed as (PLEASE CHECK ONE): ❒APRN ❒Physician Assistant ❒Physician

License Number: _____ State/Country Licensed: _____

TB TESTING

PPD DATE: _____(must be within last 12 months) RESULTS: _____
QuantiFERON/TB Gold Date: _____

-OR-
CHEST X-RAY IF POSITIVE PPD
RESULTS _____
DATE: _____
(must be within last 12 months)

Signature: _____

Name: _____

Title: _____

Location: _____

Revised: 07.31.2024