

R.B. Turnbull, Jr. MD School of Wound, Ostomy & Continence Nursing Education Program  
**Health Requirements for WOC Clinical Experience**

Student Name: \_\_\_\_\_

Date of Exam: \_\_\_\_\_

**Is the applicant:**

Free from communicable/infectious disease?	Yes	No
Able to handle and lift patients?	Yes	No
Have manual and finger dexterity?	Yes	No
Have eye/hand coordination within normal limits?	Yes	No
Able to stand/walk for extensive periods of time?	Yes	No
Able to lift/carry items weighing up to 50 pounds?	Yes	No
Able to hear and have vision corrected to normal range?	Yes	No

**Immunization Record (must have been administered within last 10 years or a titer is required; if available):**

**Hepatitis B Immunity:**

- ☐ Documented positive/negative immunity status from positive titer on: (date) \_\_\_\_\_ **or,**
- ☐ Declination of Hepatitis B Vaccine form signed and attached. **or,**
- ☐ Hepatitis Vaccination: Date of 1<sup>st</sup> vaccination \_\_\_\_\_  
Date of 2<sup>nd</sup> vaccination \_\_\_\_\_  
Date of 3<sup>rd</sup> vaccination \_\_\_\_\_

**Last Tetanus Diphtheria booster date:** \_\_\_\_\_ (strongly recommended if greater than 7 years)

**Measles, Mumps, Rubella (MMR) Immunity:**

- ☐ Laboratory evidence of immunity or positive titer on \_\_\_\_\_ (date) (attach lab copy) **or,**
- ☐ Documentation of two (2) doses of live measles and mumps vaccine given at least 28 days apart and one (1) dose of live rubella vaccine. Please indicate if combined vaccination of MMR.  
Date of 1<sup>st</sup> measles & mumps vaccination \_\_\_\_\_  
Date of 2<sup>nd</sup> measles & mumps vaccination \_\_\_\_\_  
Date of live rubella vaccination \_\_\_\_\_

**Varicella (Chicken Pox) Immunity:**

- ☐ Laboratory evidence of immunity or disease \_\_\_\_\_ (date) (attach lab copy) **or,**
- ☐ History of varicella or herpes zoster based on physician diagnosis \_\_\_\_\_ (date) **or,**
- ☐ Documentation of two (2) doses of varicella vaccine given at least 28 days apart.  
Date of 1<sup>st</sup> vaccination \_\_\_\_\_  
Date of 2<sup>nd</sup> vaccination \_\_\_\_\_

**Tuberculosis (TB) (must be current within past 12 months):**

- ☐ TB Skin Test Date: \_\_\_\_\_ Result: \_\_\_\_\_
- ☐ TB Gamma Interferon (blood draw) **or,**
- ☐ Quantiferon-B Gold-Tube Assay (QTF)
- ☐ History of positive PPD: CXR date \_\_\_\_\_ (within one year).

**Flu Vaccine (for clinicals during flu season months of October through March):** Date Admin. \_\_\_\_\_

**COVID-19 Vaccine (all CDC required doses must full administered before the cohort's first day of class):**

*Pfizer-BioNTech (BNT162b2)*

Date of 1<sup>st</sup> Dose \_\_\_\_\_

Date of 2<sup>nd</sup> Dose \_\_\_\_\_

Date of Booster \_\_\_\_\_

*Moderna (mRNA-1273)*

Date of 1<sup>st</sup> Dose \_\_\_\_\_

Date of 2<sup>nd</sup> Dose \_\_\_\_\_

Date of Booster \_\_\_\_\_

*Johnson & Johnson (JNJ-78436735)*

Date of 1<sup>st</sup> Dose \_\_\_\_\_

Date of 2<sup>nd</sup> Dose \_\_\_\_\_

Date of Booster \_\_\_\_\_

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I hereby certify \_\_\_\_\_ is in a state of physical and mental health to participate in the didactic courses and that would allow safe clinical practice. The above information is true and correct. I willingly submit to all tests necessary to complete this examination. I authorize the release of information to the appropriate school personnel.

**Medical Examiner Name (print):** \_\_\_\_\_

**Medical Examiner Signature:** \_\_\_\_\_

**Medical Examiner Title:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Student Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_