**Immunization Requirements & TB Screening Form**
for
Vanderbilt University Medical School Students

**COMPLETION OF THIS FORM IS REQUIRED FOR REGISTRATION**

**DUE MAY 15, 2016**

### STUDENT DEMOGRAPHIC INFORMATION

<table>
<thead>
<tr>
<th>Date Form Completed:</th>
<th>__________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td>First Name</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>SS# (for secure medical record)</td>
</tr>
<tr>
<td>Male / Female / Transgender</td>
<td></td>
</tr>
<tr>
<td>Area of Study (check one):</td>
<td>Hearing and Speech □  Medical □  Medical Physics □</td>
</tr>
</tbody>
</table>

### VANDERBILT MEDICAL CENTER (VUMC) and STUDENT HEALTH CENTER OUTPATIENT REGISTRATION INFORMATION

| Were you born at or have been treated at VU Medical Center, Hospital, Clinic or ED? | □ YES □ NO |
| Nashville Address (if known): | |
| Zip | Local Phone # (__) | Cell Phone # (__) |
| E-mail address | |

**EMERGENCY CONTACT**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship to Student</td>
<td>Home Phone # (__)</td>
</tr>
<tr>
<td>Work Phone # (__)</td>
<td>Cell Phone # (__)</td>
</tr>
</tbody>
</table>
Medical Student Immunization History

**Pages 2-4 Must be completed and signed by a licensed healthcare provider.**

### REQUIRED IMMUNIZATIONS AND TITERS

1. **Hepatitis B**
   - Month/Day/Year
   - Dose #1
     - _______/_________/_______
   - Dose #2
     - _______/_________/_______
   - Dose #3
     - _______/_________/_______
   - If series was completed in the last 3 months, titer is strongly recommended to assess response
   - Hep B Titer Date
     - _______/_________/_______ Immune or Non Immune

2. **Measles, Mumps, Rubella**
   - Month/Day/Year
   - Dose #1
     - _______/_________/_______ (Must be on or after 12 months of age)
   - Dose #2
     - _______/_________/_______ (Must be 28 days or more after 1st dose)
   - If no records are available, titer is required
   - Measles Titer Date
     - _______/_________/_______ Immune or Non Immune
   - Mumps Titer Date
     - _______/_________/_______ Immune or Non Immune
   - Rubella Titer Date
     - _______/_________/_______ Immune or Non Immune

3. **Varicella**
   - Month/Day/Year
   - Dose #1
     - _______/_________/_______ (Must be on or after 12 months of age)
   - Dose #2
     - _______/_________/_______ (Must be 28 days or more after 1st dose)
   - OR
   - Varicella Titer Date
     - _______/_________/_______ Immune or Non Immune

4. **Tdap**
   - Month/Day/Year
   - One-Time Adult Booster
     - _______/_________/_______

5. **Polio Primary Series**
   - Month/Day/Year
   - Date of Last Dose
     - _______/_________/_______ IPV or OPV

**Note that an annual Flu Vaccination will be required after arrival for Fall 2016.**

### Recommended Immunizations

1. **Hepatitis A**
   - Month/Day/Year
   - Dose #1
     - _______/_________/_______
   - Dose #2
     - _______/_________/_______

2. **HPV**
   - Dose #1
     - _______/_________/_______
   - Dose #2
     - _______/_________/_______
   - Dose #3
     - _______/_________/_______

3. **Meningococcal**
   - Type: A,C,Y,W and/or Type B: (Trumenba or Bexsero)
   - Dose #1
     - _______/_________/_______
   - Dose #2 (if applicable)
     - _______/_________/_______
   - Dose #3 (if applicable)
     - _______/_________/_______

4. **Others List Vaccines and Dates:**
   - Type:
     - _______/_________/_______
# Medical Student Tuberculosis History

## REQUIRED TUBERCULOSIS SCREENING

*Select #1 or #2*

1. **Complete #1 if you have History of + PPD or IGRA:**
   - **Date:** 
     - Month/Day/Year
     - (____ mm induration if PPD)
   - **Treatment Completed?**
     - Yes-Date Completed: 
       - Month/Day/Year
     - No
   - *If + PPD or IGRA, a chest x-ray is required April 1, 2016 or later:*
     - **Date of Chest X-ray:** 
       - Month/Day/Year
       - Normal or Abnormal

2. **Complete if you have NO History of + PPD or IGRA:**
   *Note that you must still have an IGRA or 2 step PPD dated April 1, 2016 or later, regardless of history*
   - **IGRA**
     - Month/Day/Year
     - Positive or Negative
   - *If newly documented positive, a chest x-ray is required April 1, 2016 or later:*
     - **Date of Chest X-ray:** 
       - Month/Day/Year
       - Normal or Abnormal
   - **Has Treatment started?**
     - Yes
     - No
   - **2 step PPD**
     - **Test #1**
       - Month/Day/Year
     - Positive or Negative
       - (____ mm induration)
     - **Test #2 (1-3 weeks later)**
       - Month/Day/Year
       - Positive or Negative
       - (____ mm induration)
Medical Student Health History

HEALTH HISTORY INFORMATION

Student’s Name ___________________________  Student’s Date of Birth ___________________________

Current Weight ___________________________  Current Height ___________________________

Current Diagnoses or Pertinent Past Medical History*:  
1. ________________________________  2. ________________________________
3. ________________________________  4. ________________________________

*Students with blood-borne infections (HIV, Hepatitis C, and Hepatitis B) will be required to undergo further health screening at the Student Health Center upon arrival on campus. It is a university policy that these infections are self-disclosed by healthcare students and employees so that continuity of care for the student is arranged and patient safety is assured.

Allergies  □ None

1. ________________________________  2. ________________________________

Current Medications:  □ None

1. ________________________________  2. ________________________________
3. ________________________________  4. ________________________________

PSYCHIATRIC WELLNESS INFORMATION

Do you have any of the following diagnostic concerns?

1. Attention Deficit Hyperactivity Disorder  
   - Yes  - No  
   - Current  - Past

2. Anxiety  
   - Yes  - No  
   - Current  - Past

3. Bipolar disorder  
   - Yes  - No  
   - Current  - Past

4. Depression  
   - Yes  - No  
   - Current  - Past

5. Eating Disorder (Anorexia or Bulimia Nervosa)  
   - Yes  - No  
   - Current  - Past

6. Treatment for alcohol or other drug treatment  
   - Yes  - No  
   - Current  - Past

7. Other ________________________________  
   - Yes  - No  
   - Current  - Past

I certify the accuracy of the health information that I have provided Vanderbilt University.
If I have recommended follow-up on the Vanderbilt campus, I have asked the student and his/her family to contact the appropriate resources prior to arrival to campus.

Student Health Center 615-322-2427
Psychological and Counseling Center 615-322-2571

Name ___________________________ (Printed or stamped name of healthcare provider)

Address ____________________________________________________________________________

Phone # ( ) ______________________

Signature ___________________________  Date ___________________________
INSTRUCTIONS FOR STUDENTS RETURNING THIS FORM:

1. After Provider completes and signs form, visit our Vanderbilt Student Health Portal at - [http://vanderbilt.studenthealthportal.com](http://vanderbilt.studenthealthportal.com). There is also a link directly from our SHC website [www.medschool.vanderbilt.edu/student-health/immunization-requirements](http://www.medschool.vanderbilt.edu/student-health/immunization-requirements).

2. Create an account using your VUnet ID and follow instructions to enter immunization dates in your “Pending Forms”. Select form for Medical Students.

3. After entering the immunization dates, press submit. **You will then UPLOAD your scanned document directly to our Student Health Portal.**

4. If you are unable to UPLOAD, you may fax or mail the 4 page form by 5/15/16. Our fax number is 615-343-0047. Our address is: Vanderbilt Student Health Center, Zerfoss Bldg., Sta. 17, F3200, Nashville, TN 37232-8710.

5. Review Health Insurance information below and submit online waiver (if applicable) by 8/1/16.

HEALTH INSURANCE WAIVER INFORMATION

**All students are REQUIRED to have Health insurance coverage, in the event hospitalization or care outside the Student Health Center is needed.**

The Vanderbilt University Student Health Center works with a private company (Gallagher Student Health Insurance and Risk) to offer an insurance policy for all Vanderbilt students who have no other coverage. For information about Gallagher, you may contact their website at [www.gallagherstudent.com](http://www.gallagherstudent.com).

The cost of the policy is automatically billed to your student account.

If you have Health Insurance from another policy (for example, you are covered under your parent’s policy or employer policy) and wish to decline the Student Health Insurance, you must submit an online waiver of this plan by **August 1, 2016**.

If you do not waive insurance by August 1, 2016, you will be automatically billed and enrolled.

You may obtain a waiver at [www.gallagherstudent.com/vanderbilt](http://www.gallagherstudent.com/vanderbilt). Please have your current health insurance ID card ready as you will need this information in order to complete the waiver form.

Instructions:
- Select **Student Waive**- Your user ID is your complete Vanderbilt University email address and your password is your full Commodore ID number (located on your Student Account).
- Select **I Want to Waive** (red button)- Complete the form and review for accuracy.
- Select **Submit**
- Save the confirmation number and print a copy of the confirmation for your records.

*Note that all submitted waiver forms will be subject to waiver verification. Most are verified within 24-48 hours. You will receive an email notification once your waiver has been verified. You can also check the status online at [www.gallagherstudent.com/Vanderbilt](http://www.gallagherstudent.com/Vanderbilt).*

- For more information regarding the student insurance requirements and the waiver procedure, please visit the Student Health website at: [www.medschool.vanderbilt.edu/student-health/student-health-insurance](http://www.medschool.vanderbilt.edu/student-health/student-health-insurance)