Student Demographics and Immunization History

Immunization Compliance is required for Registration

Due 12/1 for Spring, 5/1 for Summer & 5/15 for Fall Admission

VANDERBILT UNIVERSITY STUDENT DEMOGRAPHIC INFORMATION

Date: ____________________

Last Name ________________________________  First Name ____________________  M.I.______

Date of Birth ______-______-______  SS# (part of secure VUMC medical record only) ________________

Mo.  Day  Year

Please circle: Male / Female / Transgender

Graduate Program Enrollment:

Graduate □  Law □  Divinity □  Owen □  Peabody □  Other □

Term Entering:  Spring □  Summer □  Fall □  Full-time ( >8 hrs. grad) □  or  Part-time □

Distance learner? Yes □  No □

VANDERBILT MEDICAL CENTER (VUMC) & 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 # (____)_______________  Student Cell Phone # (____)_______________

Student E-mail address______________________________________________________________

Home E-mail address______________________________________________________________

EMERGENCY CONTACT INFORMATION

Last Name ________________________________  First Name ________________________________

Relationship to Student ______________________  Home Phone # (____)_______________________

Work Phone # (____)_______________________  Cell Phone # (____)_______________________

Parent/Guardian Signature - Consent for Treatment of minor (Below age 18): I authorize and consent to the routine treatment of my child by the physicians and nursing staff of the Vanderbilt University Student Health Center.

Name ________________________________  Relationship ________________________________

I ________________________________ give permission for Vanderbilt Student Health to email ________________ (parent or Legal guardian) at ________________, if there are immunization compliance questions or need for further documentation.

Student Signature ________________  Date ________________
### Immunization History Information

**Immunization History Information**

**TO BE COMPLETED BY A HEALTH CARE PROVIDER**

**IMMUNIZATION INFORMATION**

<table>
<thead>
<tr>
<th>Student’s Name</th>
<th>Student’s Date of Birth</th>
</tr>
</thead>
</table>

**STATE MANDATED IMMUNIZATIONS –**

<table>
<thead>
<tr>
<th>Registration will be held if not compliant</th>
<th>Date Administered (Month –Day-Year)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>M.M.R. (MEASLES, MUMPS, RUBELLA)</th>
<th>#1 <em><strong>-</strong>-</em>_</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Two doses required, at least 28 days apart for students born after 1956.)</td>
<td>#2 <em><strong>-</strong>-</em>_</td>
</tr>
<tr>
<td>Dose 1 given at age 12 months or later</td>
<td>#1 <em><strong>-</strong>-</em>_</td>
</tr>
<tr>
<td>Dose 2 given at least 28 days after first dose</td>
<td>#2 <em><strong>-</strong>-</em>_</td>
</tr>
</tbody>
</table>

If unable to locate MMR documentation, then submit positive titer results -

Positive Titer Results □ Yes (Official lab results must be attached) Date of titer: ___-__-__

**VARICELLA**

If you were born after 1980, you need proof of -

2 vaccinations OR History of the Disease OR Official positive titer results.

- Dose #1 given at age 12 months or later
- Dose #2 given at least 28 days after first dose
- History of Disease □ Yes (Month/Day/Year of disease ___ - ____ - ____)
- Positive Titer Results □ Yes (Official lab results must be attached)

□ Exempt (born before 1980)

**RECOMMENDED IMMUNIZATIONS**

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Date Administered (M-D-Y)</th>
</tr>
</thead>
</table>

**HEPATITIS A –**

- Dose #1…………………………………………………………………………………………… #1 ___-__-__
- Dose #2 (given 6-12 mo. after first)………………………………………………………… #2 ___-__-__

**HEPATITIS B**

- Dose #1…………………………………………………………………………………………… #1 ___-__-__
- Dose #2 (1-2 mo. after 1st)…………………………………………………………………… #2 ___-__-__
- Dose #3 (4-6 mo. after 1st)…………………………………………………………………… #3 ___-__-__

**HPV**

- Dose #1…………………………………………………………………………………………… #1 ___-__-__
- Dose #2 (1-2 mo. after 1st)…………………………………………………………………… #2 ___-__-__
- Dose #3 (4-6 mo. after 1st)…………………………………………………………………… #3 ___-__-__

**MENINGOCOCCAL -A,C,Y,W (eg. Menactra) –**

Dose most recently received (usually prior to undergrad college entry)………………... ___-__-__

**POLIO (primary series required for all students)**

- Date of last immunization……………………………………………………………………… #1 ___-__-__
- □ IPV □ OPV

**TETANUS-DIPHTHERIA-PERTUSSIS**

- Tdap (Preferred- may be given regardless of last dT booster)…………………………... ___-__-__
- OR
dT booster within 10 years ………………………………………………………………………… ___-__-__

For Office Use Only:
MRN ____________________
DOB ____________________
# Tuberculosis Assessment

TO BE COMPLETED BY A HEALTHCARE PROVIDER

## TB Screening Questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the student ever had a positive TB skin test?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Has the student recently had close contact with somebody ill with TB?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Has the student ever spent more than 6 weeks in Eastern Europe, Africa, Asia, Middle East or South/Central America?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Has the student been vaccinated with BCG?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Has the student been an employee or volunteer in a prison, homeless shelter, nursing home or hospital?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Does the student have a suppressed immune system?</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

If YES is circled for any above, proceed to section below.

If NO is circled for ALL, proceed to page 4.

## Provider- Complete ONE of the tables below (NO HISTORY or POSITIVE HISTORY) if any TB screening question above is YES:

### NO PAST HISTORY OF (+) PPD or IGRA

**PPD or IGRA required within 6 months regardless of BCG history**

<table>
<thead>
<tr>
<th>PPD**</th>
<th>Date Given:</th>
<th>Date Read:</th>
<th>Induration:</th>
<th>Positive or Negative (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong><strong>/</strong></strong>/____</td>
<td><strong><strong>/</strong></strong>/____</td>
<td>mm**</td>
<td></td>
</tr>
</tbody>
</table>

If newly documented positive, a chest x-ray is also required within the last 6 months:

<table>
<thead>
<tr>
<th>Date of Chest X-ray:</th>
<th>Results: Normal or Abnormal (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>/</strong>/____</td>
<td></td>
</tr>
</tbody>
</table>

If yes, Date of Treatment: __/__/____

Provider- Please provide a copy of x-rays or IGRA results to student to submit with this form to Vanderbilt SHC.

### HISTORY OF POSITIVE (+) PPD or IGRA

Complete lines below depending on history of positive PPD or positive IGRA

<table>
<thead>
<tr>
<th>(+) PPD**</th>
<th>Date:</th>
<th>Date Read:</th>
<th>Induration:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong><strong>/</strong></strong>/____</td>
<td><strong><strong>/</strong></strong>/____</td>
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</thead>
<tbody>
<tr>
<td><strong>/</strong>/____</td>
<td></td>
</tr>
</tbody>
</table>

If yes, Date of Treatment: __/__/____

Provider- Please provide a copy of x-rays or IGRA results to student to submit with this form to Vanderbilt SHC.

### **PPD Interpretation Guidelines**

<table>
<thead>
<tr>
<th>&gt; 5mm is positive:</th>
<th>&gt;10 mm is positive:</th>
<th>&gt;15 mm is positive if no risk factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent close contact with person with active TB</td>
<td>Significant travel or residence in high prevalence area</td>
<td></td>
</tr>
<tr>
<td>Abnormal CXR c/w past TB disease</td>
<td>Illicit drug use</td>
<td></td>
</tr>
<tr>
<td>Organ transplant or other immunosuppression</td>
<td>Worker in healthcare, homeless shelter, prisons</td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Chronic health issues, as per above screening questions</td>
<td></td>
</tr>
</tbody>
</table>
Student Health History & Wellness Questionnaire
TO BE COMPLETED BY A HEALTH CARE PROVIDER

HEALTH HISTORY INFORMATION

Student’s Name_________________________ Student’s Date of Birth ____________________________

Student’s Cell Phone _____________________

Current Weight_______ Current Height ______ Current BMI_______

Is assessment by a dietician or physician recommended upon arrival to campus? □ Yes □ No

Current Diagnoses or Pertinent Past Medical History: □ None
1. ________________________________
2. ________________________________
3. ________________________________

Allergies: □ None
1. ________________________________ 2. ________________________________

Current Medications: □ None
1. ________________________________
2. ________________________________
3. ________________________________

MENTAL HEALTH WELLNESS INFORMATION

Does the student have any history, past or current, of the following diagnoses?

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. Is the student currently taking psychotropic medications? Yes No
   ▪ If yes, are you the prescriber? Yes No

I certify the accuracy of the health information that I have provided Vanderbilt University.

Name ____________________________________________ (Printed or stamped name of healthcare provider)

Address________________________________________________________________________________

Phone # ( ) ______________________________

Provider Signature ___________________________________________ Date ________________

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 https://medschool.vanderbilt.edu/student-health/
Psychological and Counseling Center 615-322-2571 https://medschool.vanderbilt.edu/pcc/
Important Checklist and Insurance Instructions:

1. After your provider has completed this form, you must enter immunization history dates (found on page 2 of this document) in our Vanderbilt University Student Health Portal at https://vanderbilt.studenthealthportal.com.  (Note:  You will need to set up a new account first by using your VUnetID.  A unique password will then be emailed to you and you can log in at that time).

2. Scan and upload all 4 pages to the VU Student Health Portal.  This is the best method for faster processing.  If you are unable to use the portal, you may mail or fax your 4 page document to the following: Vanderbilt University Student Health Center, Zerfoss Bldg., Sta. 17, F3200, Nashville, TN 37232-8710 or Fax: 615-343-0047   Attn: Immunization Compliance

3. If you are a student with chronic physical or mental health issues that need ongoing care, please visit the Student Health website https://medschool.vanderbilt.edu/student-health/ or Psychological and Counseling Center website https://medschool.vanderbilt.edu/pcc/ for more information regarding services and how to access care.  Please keep in mind that if you need specialist care, you should start early in making plans for care, since many specialists book several months in advance.

4. Read about Insurance Information:  All Students are REQUIRED to have Health Insurance coverage, in the event that 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 & Risk) to offer an insurance policy for all Vanderbilt students who have no other coverage.  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 January 1 for Spring Admits and August 1 for Fall Admits*. If you do not waive insurance by January 1 (Spring Admits) or August 1 (Fall Admits), you will be automatically billed and enrolled.

After May 1st, you may obtain a waiver at 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.  **If this is your first time logging in, please follow these 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).  You will be asked to create your own unique password.  You would then sign back in and continue with the next instruction.
- 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.

*Maymester & Summer Admits must waive the summer and annual plans via the online form available May 1.  This form is due by August 1.

- For more information about Gallagher, you may contact their website at www.gallagherstudent.com.
- For more information about the student insurance requirements and the waiver procedure, please visit the Student Health website at: www.medschool.vanderbilt.edu/student-health/student-health-insurance.