REQUIRED ADDITIONAL IMMUNIZATIONS
Vanderbilt University School of Medicine
224 Eskind Biomedical Library, Nashville TN 37240

PART I – TO BE COMPLETED BY THE STUDENT

Name:_____ Date of Birth: _____
Last First MI

Email Address: _____

Phone: ( ) _____ Prior rotations at VUMC?: □No □Yes Date of 1st rotation at VUMC: _____

PART II – TO BE COMPLETED AND SIGNED BY A LICENSED HEALTHCARE PROVIDER

A. Influenza Vaccine (in current flu season if rotating September 1-March 31): Date: _____

B. Tuberculosis Screening: Must provide proof of a 2 step-PPD or IGRA upon med school admission or since starting Medical School:

Admission to Medical School: Month/Year: _____
Date of 1st Vanderbilt Rotation: Month/Year_____

Dates of ANY 2 Step from Med School admission or since starting Medical School:

PPD #1 Date _____ □Positive □Negative
PPD #2 Date _____ □Positive □Negative
OR
IGRA Date_____ □Positive □Negative

****If a 2 step PPD or IGRA has not been completed on med school admission or since starting medical school, this requirement will be met by having one negative PPD within one year of the 1st rotation at Vanderbilt, and a second negative PPD within 3 months of the 1st rotation at Vanderbilt OR an IGRA within 3 months of the 1st rotation at Vanderbilt****

PPD within 1 year of rotation Date _____ □Positive □Negative
PPD within 3 months of rotation Date _____ □Positive □Negative
OR
IGRA within 3 months of rotation Date _____ □Positive □Negative

****Complete the section below if there is a history of a POSITIVE IGRA or POSITIVE PPD:**
History of (+) PPD or IGRA? □Yes Date: _____
If yes, treatment completed? □Yes □No If no, explain: _____

If yes, chest x-ray required to be within 6 months of 1st rotation at Vanderbilt: Date_____
If yes, must complete **Vanderbilt TB symptom Screen** annually for each Vanderbilt rotation: □ Attached

C. COVID Vaccine Primary Series: #1Date _____/Brand_____ #2 Date _____/Brand_____

If applicable: #3_____/Brand _____ If applicable: #4 _____/Brand_____

D. COVID Vaccine BiValent Booster: Date _____/Brand _____

HEALTH CARE PROVIDER

Name: _____Signature _____ Date_____
(Printed)