

Student Health Center
Vanderbilt University Medical Center
Student Demographics and Immunization History
Nursing Students
 Medical Statement – *Student Health*



Patient Label or Patient Identifiers

Due: July 1st for Fall Enrollment & Dec. 1st for Spring

Immunization & TB Compliance - Required prior to Registration

Submit this form to both- the [Student Health Portal](#) and your VUSN Castle Branch account (see- New Student Requirements on the [VUSN Admitted Students webpage](#))

Required	Vanderbilt University School of Nursing (VUSN) STUDENT DEMOGRAPHIC INFORMATION
*Date: ___/___/___	<i>Office Use Only:</i> Epic _____ Compliance _____
*Last Name: _____	*First Name: _____
*MI: _____	Preferred Name (optional): _____
*Date of Birth: ___/___/___	*Last four of SS# (secured record): ___/___/___
*Biological Sex: <input type="checkbox"/> Male / <input type="checkbox"/> Female / <input type="checkbox"/> Other	Gender Identity (optional): _____
Course Load: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Term Beginning: <input type="checkbox"/> Spring <input type="checkbox"/> Summer <input type="checkbox"/> Fall
Prior Education: <input type="checkbox"/> Non-Nursing Degree <input type="checkbox"/> ASN or Nursing Diploma <input type="checkbox"/> BSN <input type="checkbox"/> MSN <input type="checkbox"/> PMC	
Program Degree: <input type="checkbox"/> MSN <input type="checkbox"/> Post Masters Certificate (PMC) <input type="checkbox"/> DNP <input type="checkbox"/> DNP + Post Masters <input type="checkbox"/> PhD	
Nursing Specialty: _____	

**Vanderbilt University Medical Center (VUMC) & Student Health Center (SHC)
OUTPATIENT REGISTRATION INFORMATION**

Were you born at or have been treated at VU Medical Center, Hospital, Clinic or ED? YES NO

Home Address: _____

Nashville Address (if known): _____

Home Phone #: () _____ Student Cell Phone #: () _____

Student E-Mail address: _____

Primary Language if other than English: _____

EMERGENCY CONTACT INFORMATION

Last Name: _____ First Name: _____

Relationship to Student: _____ Home Phone # () _____

Work Phone # () _____ Cell Phone # () _____

Patient/Legal Representative Print Name: _____

Patient/Legal Representative Signature: _____

Relationship: _____ Date: _____ Time: _____

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Immunization History Information –
 TO BE COMPLETED AND SIGNED BY A HEALTHCARE PROVIDER

Student's Name: _____ Student's Date of Birth: _____

REQUIRED - IMMUNIZATIONS & TITERS for REGISTRATION: *Booster vaccinations are required for negative and equivocal titer results.	Date Administered (Month-Day-Year)
M.M.R. (MEASLES, MUMPS, RUBELLA) - (2-doses required <u>OR</u> Pos titer results) Dose #1 given at age 12 months or later..... Dose #2 given at least 28 days after first dose..... If no vaccination records available, titer results are required (attach lab report). <div style="text-align: right;">Measles, Mumps, Rubella Titers Date: _____ Titers Result: _____</div>	#1 _____ - _____ - _____ #2 _____ - _____ - _____ _____ - _____ - _____ Immune or *Non-Immune
VARICELLA - (2-doses required <u>OR</u> positive titer result) Dose #1 given at age 12 months or later..... Dose #2 given at least 28 days after first dose..... If no vaccination records available, titer result required (attach lab report). <i>History of chicken pox disease is not acceptable for healthcare professionals.</i> <div style="text-align: right;">Varicella titer Date: _____ Titer Result: _____</div>	#1 _____ - _____ - _____ #2 _____ - _____ - _____ _____ - _____ - _____ Immune or *Non-Immune
HEPATITIS B- (3-doses required <u>OR</u> positive titer result) Completed series required prior to clinical participation. Approval of 2-dose series requires provider documentation of the receipt of two (2) <i>HepB</i> vaccinations at least 4wks. apart. Dose #1..... Dose #2 (1-2 mo. after 1st)..... Dose #3 (4-6 mo. after 1st)..... If no vaccination records available, titer result required (attach lab report). Titer is recommended for series completed in past 3-months. <div style="text-align: right;">HepB titer Date: _____ Titer Result: _____</div>	#1 _____ - _____ - _____ #2 _____ - _____ - _____ #3 _____ - _____ - _____ _____ - _____ - _____ Immune or *Non-Immune
TDAP- (1-dose in past 10-years required) DTP/DTap and Td/TD vaccines do not meet this requirement. <div style="text-align: right;">TDAP Date: _____</div>	_____ - _____ - _____
Note: The seasonal influenza vaccination is required by Oct. 15 th for all VUSN students. Waiver requests must be submitted by Oct. 1 st through: https://www.vumc.org/student-health/influenza-vaccinations-students	

OPTIONAL REPORTING:	
COVID-19 <input type="checkbox"/> AstraZeneca <input type="checkbox"/> Janssen (J&J) <input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer <input type="checkbox"/> Other Dose #1..... Dose #2.....	#1 _____ - _____ - _____ #2 _____ - _____ - _____
HEPATITIS A Dose #1..... Dose #2 (given 6-12 mo. after first).....	#1 _____ - _____ - _____ #2 _____ - _____ - _____
HPV Dose #1..... Dose #2 (1-2 mo. after 1st)..... Dose #3 (4-6 mo. after 1 st).....	#1 _____ - _____ - _____ #2 _____ - _____ - _____ #3 _____ - _____ - _____
MENINGOCOCCAL - A,C,Y,W (eg. Menactra, Menveo) – Dose most recently received (usually prior to undergrad college entry)	_____ - _____ - _____
MENINGOCOCCAL – SEROTYPE B (eg. Trumenba or Bexsero after 2015) Dose #1 (Bexsero or Trumenba)..... Dose #2 (Bexsero or Trumenba)..... Dose #3 (if Trumenba and high risk).....	<input type="checkbox"/> Bexsero <input type="checkbox"/> Trumenba #1 _____ - _____ - _____ #2 _____ - _____ - _____ #3 _____ - _____ - _____
POLIO Primary Series (Date of last dose).....	_____ - _____ - _____ IPV or OPV

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REQUIRED - Tuberculosis History & Screening for VUSN

TO BE COMPLETED BY A HEALTHCARE PROVIDER

Student's Name: _____ Student's Date of Birth: _____

Note to VUSN Student- Prior TB testing must fall within dates below to be acceptable.

Note to Provider - Please administer the PPD(s) or IGRA as indicated and note results below.

<i>Complete this table if student has no past history of (+) PPD or IGRA</i>			
NO PAST HISTORY OF (+) PPD or IGRA	All New Admits must submit a PPD #1:	Given: ____/____/____ Must be administered on/after August 10, 2020	Date Read: ____/____/____ (within 3 days of placement) Induration: _____ mm** Positive or Negative
	Non-RN Students must <u>also</u> submit a PPD #2:	Given: ____/____/____ Must be administered on/after May 10, 2021	Date Read: ____/____/____ (within 3 days of placement) Induration: _____ mm** Positive or Negative
	-OR- All New Admits can submit an IGRA:	Date: ____/____/____ Must be completed on/after May 10, 2021	Positive or Negative (circle) (Attach lab report for verification)
	If newly documented Positive, a Chest X-ray is required <u>after</u> Feb 10, 2021:	Date of Chest X-Ray: ____/____/____ Results: Normal or Abnormal (circle) <i>Provider- Please provide a copy of x-rays or IGRA results to student to submit with this form.</i>	Student must immediately notify local health department and their VUSN Program Director- Treatment Started: Yes or No (circle) If yes, Date of Treatment: ____/____/____

<i>Complete this table depending on history of positive PPD or positive IGRA</i>			
HISTORY OF POSITIVE (+) PPD or IGRA	(+) PPD**	Date of prior positive PPD: ____/____/____	Induration: _____ mm** Repeat PPD not needed
	(+) IGRA	Date: ____/____/____	Repeat IGRA not needed
	Chest X-ray required <u>on/after</u> Feb 10, 2021 for new admits with a previous positive:	Date of Chest X-Ray: ____/____/____ Results: Normal or Abnormal (circle) <i>Provider-Please provide a copy of x-rays or IGRA results to student to submit with this form.</i>	Treatment Completed: Yes or No [†] (circle) If yes, Date Completed: ____/____/____ [†]If no, student must immediately notify local health department and their VUSN Program Director.

****PPD Interpretation Guidelines**

>5mm is positive:	>10 mm is positive:	>15 mm is positive if no risk factors
-Recent close contact with person with active TB -Abnormal CXR c/w past TB disease -Organ transplant or other immunosuppression -HIV/AIDS	-Immigration from high prevalence area within 5 years -Illicit drug use -Worker in healthcare, homeless shelter, prisons -Chronic Health Issues, as per above questions	

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Student Health History & Wellness Questionnaire
TO BE COMPLETED BY A HEALTH CARE PROVIDER

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. _____

**Students with blood-borne infections (HIV, Hepatitis B, Hepatitis C) will be required to undergo further health screening at the Student Health Center upon arrival on campus. It is a VUMC policy that these infections are self-disclosed by healthcare students and employees so that the continuity of care for the student is arranged and patient safety is assured. No private health information is disclosed to the School of Nursing.*

Allergies: None

1. _____
2. _____

Current Medications: None

1. _____
2. _____
3. _____

Health Provider Release for Nursing Program - Provider signature below confirms the patient named above was examined and deemed mentally and physically capable of carrying out assignments in a nursing school program AND certifies the accuracy of the health information provided on this form.

REQUIRED - Provider Signature: _____ Date: _____

Provider Print Name: _____
(Printed or stamped name of healthcare provider--- may not be a family member of the student)

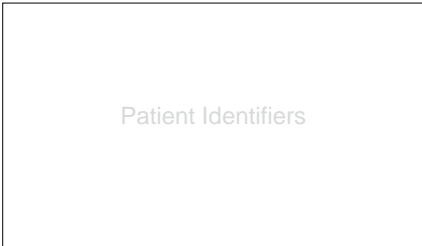
Address: _____

Phone #: () _____

If I have recommended follow-up on the Vanderbilt campus due to chronic illness or mental health issues that need ongoing care, I have asked the student to contact the appropriate resources prior to arrival to campus.

Student Health Center 615-322-2427 <https://vumc.org/student-health/>

University Counseling Center 615-322-2571 <https://vanderbilt.edu/ucc/>



Compliance for Registration:

Deadline: July 1 for fall enrollees & Dec. 1 for spring (*allow 10-business days for approval*)

Have a health provider complete the required immunizations, titers and testing on this form and sign the Health Provider Release statement.

If you have previously completed these items, your documentation must be from the following sources for approval- official medical, state, county, or international immunization records.

Note- A signature for the *Health Provider Release* is required, regardless of acceptable documentation for previously completed requirements.

Submit this health form to the Student Health Center:

(verification of state-mandated immunizations)

Step 1	Since you are a new student, you will need to create an account in our student health portal at https://vanderbilt.studenthealthportal.com . You must wait 24 hours from claiming your VUNet ID to use this unique HIPAA compliant system. After logging in, click on the link to register, enter the requested info, and a unique password will be emailed to you within minutes.
Step 2	After you receive your password and log back into the portal, go to FORMS and enter your immunization vaccinations dates into the portal (these are the dates on page 2 of our form).
Step 3	Scan and upload all 4 pages of our form + any additional immunization records that you may have by using the DOCUMENT UPLOAD tab. Save your hard copies in a secure location.
Step 4	Allow Student Health 7 business days to review your documentations and verify compliance. Student Health will send you a confirmation message (via the portal) when your records have been reviewed and <u>accepted</u> for compliance. If they have not been accepted, you will get a next steps message. The registrar's office will then remove your registration hold in the YES system and you can register at your assigned time.

-AND-

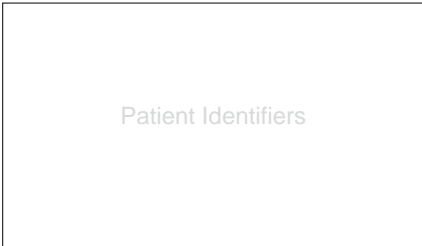
Submit this health form to the School of Nursing:

(verification of enrollment requirements)

Follow instructions under **New Student Requirements** on the [VUSN Admitted Students webpage](https://nursing.vanderbilt.edu/students/admitted/index.php) nursing.vanderbilt.edu/students/admitted/index.php to order a Castle Branch background check. This order creates your **myCB** account, *To-Do-List*. Submit this health form and documentation of any previously completed items to their applicable requirement(s). Note- Check your myCB account for document approval. Additional information or follow-up may be required to register.

Caution- Time sensitive action!

VUSN students who prefer to use their personal health insurance coverage while enrolled **must waive the University's student insurance coverage by Aug. 1st for fall enrollees and Jan. 1st for spring enrollees** (see instructions on pg. 6).



Insurance Waiver Instructions (for domestic students only):

All Students are **REQUIRED** to have health insurance coverage, in the event that hospitalization or care outside the Student Health Center is needed. The SHC works with a private company 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.

However, if you have health insurance from another policy (for example, you are covered under your parent policy or employer policy) and wish to decline the student health insurance, **you must submit an online waiver of this plan EACH YEAR by January 1 for Spring admits and August 1 for Fall, Maymester & Summer admits.** If you wish to complete the waiver you will need to supply supporting documentation of comparable coverage. If you do not waive insurance by the appropriate date, you will be automatically billed and enrolled in the Student Health Insurance Plan.

For more information about the student insurance requirements and the waiver procedure, please visit the Student Health website at: www.vumc.org/student-health/student-health-insurance

Due by August 1

1. Submit Insurance Coverage to Vanderbilt School of Nursing (school requirement):	
Follow instructions under New Student Requirements on the VUSN Admitted Students webpage nursing.vanderbilt.edu/students/admitted/index.php to create your myCB (Castle Branch) account and submit documentation of either, Personal or University coverage.	
Due by Aug. 15	<p>All students must provide documentation of the insurance they will be covered by as a VUSN student. Submit proof of either- the student coverage or approved personal insurance coverage with your card (<i>front & back</i>) OR a letter verifying coverage.</p> <p>Documentation must contain: the student's name, policy/plan number(s), insurance carrier's name and phone number(s). If name on card does not match the student's name, a letter from the insurance carrier that verifies coverage is required.</p> <p>Documentation of the University's student insurance is made available during the first two-weeks of August for the academic year. Pull proof and submit to your myCB account.</p>