

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



Patient Label or Patient Identifiers

Immunization Compliance is required for Registration
Due 12/1 for Spring, 5/1 for Summer & 5/15 for Fall

| VANDERBILT UNIVERSITY STUDENT DEMOGRAPHIC INFORMATION FOR UNDERGRADUATE STUDENTS | |
|---|---|
| Date: _____ | <i>For Office Use Only: Epic</i> _____ <i>Compliance</i> _____ |
| Last Name: _____ | First Name: _____ MI: _____ |
| Preferred First Name (if Applicable): _____ | |
| Date of Birth: ____/____/____ | last four of SS# (part of secure VUMC medical record only): _____ |
| Please circle: Male / Female / Other International Student: 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? <input type="checkbox"/> YES <input type="checkbox"/> 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 #: () _____ |
| Parent/Guardian Signature – Consent for Treatment of minor (Under age 18): I authorize and consent to the routine treatment of my child by the providers and nursing staff of the Vanderbilt Student Health Center. | |
| Patient/Legal Representative Print Name: _____ | |
| Patient/Legal Representative Signature: _____ | |
| Relation: _____ | Date: _____ Time: _____ |

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.

Patient/Legal Representative Print Name: _____
Patient/Legal Representative Signature: _____
Relationship: _____ Date: _____ Time: _____

Immunization Compliance & TB Requirements

The State of Tennessee requires that all students entering college present a certificate of immunization that the student has received all immunizations required by law. While your state or country of origin may have different requirements, you must comply as required by Tennessee laws and Vanderbilt University requirements.

Deadlines for submission to Immunization Records

You must be compliant with your immunizations and TB requirements to register for classes at your assigned time. Use these dates as guidelines to submit your records so that you can register appropriately:

- **Fall Semester:** May 15
- **Spring Semester:** December 1
- **Summer Semester:** May 1

New Student Checklist (Action Required)

STEP 1: Complete the online Tuberculosis Screening Form at <https://is.gd/requiredtbform>.

STEP 2: Print the PDF at the end of the completed TB Screening Form and follow the instructions provided. These instructions **may** include additional testing from a health care provider (See Step 4).

STEP 3: Complete page 1 of our form with your Student, Demographic and Emergency Contact information.

STEP 4: Have a doctor's office, clinic, or health department complete the **Immunization Requirements page & Health History page**. The provider must also complete **TB testing** from **STEP 2** (if applicable). *If unable to have a provider complete these pages by the deadline, you may also attach official signed/stamped immunization records (in English).* TB testing must be current.

STEP 5: As a first-time user, register for our unique HIPAA compliant Vanderbilt Student Health Portal (<https://vanderbilt.studenthealthportal.com>). Follow instructions in portal to register. *Note that you won't have access to this portal until you have claimed your VUnetID and waited 24 hours.*

STEP 6: Once in the portal, go to "My Forms" at the top toolbar. Click on GRAD/UGRD and enter your immunization dates from your hard copy pages into the portal and "Submit" them into the system.

STEP 7: Go to "Document Upload" at the top toolbar and attach your **TB Questionnaire and Immunization/Health History** scans. If you have additional documents to upload (TB tests, lab reports for titers) upload these as well. Student Health cannot begin the review until we receive your scans.

STEP 8: Monitor your email. Communications regarding compliance or next steps can be found by logging into <https://vanderbilt.studenthealthportal.com> and clicking "Messages" in the toolbar. Once compliant, your registration hold will be removed in the Vanderbilt YES system allowing you to register for classes during your assigned time.

STEP 9: Waive Student Health Insurance if applicable.
Go to <https://vmc.org/student-health/student-health-insurance> for more information by the deadline. Failure to comply will result in charges to account.

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

IMMUNIZATION AND TB INFORMATION

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

| REQUIRED STATE MANDATED IMMUNIZATIONS - *Registration will be held if not compliant | Date Administered (Month-Day-Year) |
|--|--|
| *M.M.R. (MEASLES, MUMPS, RUBELLA) If you were born after 1956- 2 Vaccinations OR Official positive titer results are required. Dose #1 given at age 12 months or later..... Dose #2 given at least 28 days after first dose..... If unable to locate information, attach positive titer results lab report <input type="checkbox"/> Yes, attached | #1 _____ - _____ - _____ #2 _____ - _____ - _____ |
| *VARICELLA If you were born after 19802 vaccinations OR positive titer results OR history of disease are required. • Dose #1 given at age 12 months or later..... Dose #2 given at least 28 days after first dose..... • Positive Titer results (Official lab results must be attached) <input type="checkbox"/> Yes, attached • HISTORY OF DISEASE accepted for domestic/non-international students only Date of Chicken Pox Disease (Month-Day-Year) _____ - _____ - _____ | #1 _____ - _____ - _____ #2 _____ - _____ - _____ <input type="checkbox"/> Exempt (born before 1980) |
| *MENINGOCOCCAL – A, C, Y, W (eg. Menactra, Menveo) – One dose given at age 16 or older for students living on campus Enter the date of the most recent Meningococcal vaccination..... | Enter date of most recent meningococcal ACYW dose: _____ - _____ - _____ |
| * TB Screening Survey Completed <input type="checkbox"/> Yes, pdf attached | |
| RECOMMENDED IMMUNIZATIONS | Date Administered (Month-Day-Year) |
| 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 _____ - _____ - _____ |
| HEPATITIS B Dose #1..... Dose #2 (1-2 mo. after 1st)..... Dose #3 (4-6 mo. after 1st)..... | #1 _____ - _____ - _____ #2 _____ - _____ - _____ #3 _____ - _____ - _____ |
| HPV Dose #1..... Dose #2 (1-2 mo. after 1st)..... Dose #3 (4-6 mo. after 1 st)..... | #1 _____ - _____ - _____ #2 _____ - _____ - _____ #3 _____ - _____ - _____ |
| MENINGOCOCCAL – SEROTYPE B (eg. Trumenba or Bexsero) Providers- Please review carefully- This vaccine was CDC approved in 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 required for all students) Date of last polio immunization..... | <input type="checkbox"/> IPV <input type="checkbox"/> OPV _____ - _____ - _____ |
| TETANUS-DIPHTHERIA-PERTUSSIS Tdap (Record adolescent dose. If no adolescent dose, list Tdap Booster)..... | - - - |

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

HEALTH HISTORY INFORMATION

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

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. _____

I certify the accuracy of the health information that I have provided Vanderbilt Student Health Center.

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

Address: _____

Phone #: () _____

Provider Signature: _____ Date: _____ Time: _____

If I have recommended a follow-up visit due to chronic illness or mental health issues that need ongoing care, 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://vumc.org/student-health/>
University Counseling Center - 615-322-2571 <https://vanderbilt.edu/ucc/>