# Student Health Center
## Vanderbilt University Medical Center
### Student Demographics and Immunization History
#### Nursing Students

**Medical Statement – Student Health**

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**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)

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## Required Vanderbilt University School of Nursing (VUSN) STUDENT DEMOGRAPHIC INFORMATION

<table>
<thead>
<tr>
<th>Required</th>
<th>Vanderbilt University School of Nursing (VUSN) STUDENT DEMOGRAPHIC INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date:</strong></td>
<td><em><strong>/</strong></em>/______</td>
</tr>
<tr>
<td><strong>Office Use Only:</strong></td>
<td>Epic Compliance</td>
</tr>
</tbody>
</table>

### *Date:__/__/______

**Last Name:**

**First Name:**

**MI:**

Preferred Name *(optional)*:

**Date of Birth:** __/__/______

**Last four of SS#** *(secured record)*: __/__/______

**Biological Sex:**

- [ ] Male
- [ ] Female
- [ ] Other

**Gender Identity *(optional)*:**

**Course Load:**

- [ ] Full-Time
- [ ] Part-Time

**Term Beginning:**

- [ ] Spring
- [ ] Summer
- [ ] Fall

**Prior Education:**

- [ ] Non-Nursing Degree
- [ ] ASN or Nursing Diploma
- [ ] BSN
- [ ] MSN
- [ ] PMC

**Program Degree:**

- [ ] MSN
- [ ] Post Masters Certificate (PMC)
- [ ] DNP
- [ ] DNP + Post Masters
- [ ] PhD

**Nursing Specialty:**

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## 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:**

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**Nashville Address (if known):**

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**Home Phone #: ( )** ____________________________

**Student Cell Phone #: ( )** ____________________________

**Student E-Mail address:**

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**Primary Language if other than English:**

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## EMERGENCY CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Relationship to Student:**

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**Home Phone #: ( )** ____________________________

**Work Phone #: ( )** ____________________________

**Cell Phone #: ( )** ____________________________

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**Patient/Legal Representative Print Name:**

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**Patient/Legal Representative Signature:**

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**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.*

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dose Details</th>
<th>Date Administered</th>
<th>Titer Result</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>M.M.R. (MEASLES, MUMPS, RUBELLA)</strong></td>
<td>(2-doses required OR Pos titer results)</td>
<td>#1</td>
<td>Measles, Mumps, Rubella Titer Date:</td>
</tr>
<tr>
<td></td>
<td>Dose #1 given at age 12 months or later</td>
<td>#1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dose #2 given at least 28 days after first dose</td>
<td>#2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If no vaccination records available, titer results are required (attach lab report).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>VARICELLA</strong></td>
<td>(2-doses required OR positive titer result)</td>
<td>#1</td>
<td>Varicella titer Date:</td>
</tr>
<tr>
<td></td>
<td>Dose #1 given at age 12 months or later</td>
<td>#1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dose #2 given at least 28 days after first dose</td>
<td>#2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If no vaccination records available, titer result required (attach lab report).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HEPATITIS B</strong></td>
<td>(3-doses required OR positive titer result)</td>
<td>#1</td>
<td>HepB titer Date:</td>
</tr>
<tr>
<td></td>
<td>Completed series required prior to clinical participation. Approval of 2-dose series requires provider documentation of the receipt of two (2) Hepatitis-B vaccinations at least 4wks. apart.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dose #1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dose #2 (1-2 mo. after 1st)</td>
<td>#2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dose #3 (4-6 mo. after 1st)</td>
<td>#3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If no vaccination records available, titer result required (attach lab report).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TDAP</strong></td>
<td>(1-dose in past 10-years required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DTP/DTap and Td/TD vaccines do not meet this requirement.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Notes:
- The seasonal influenza vaccination is required by Oct. 15th for all VUSN students.
- Waiver requests must be submitted by Oct. 1st through [https://www.vumc.org/student-health/influenza-vaccinations-students](https://www.vumc.org/student-health/influenza-vaccinations-students)

## OPTIONAL REPORTING:

### POLIO Primary Series (Date of last dose): __________________________

<table>
<thead>
<tr>
<th>IPV</th>
<th>OPV</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### HEPATITIS A

<table>
<thead>
<tr>
<th>Dose #</th>
<th>Date Administered</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td></td>
</tr>
<tr>
<td>#2</td>
<td></td>
</tr>
</tbody>
</table>

### HPV

<table>
<thead>
<tr>
<th>Dose #</th>
<th>Date Administered</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td></td>
</tr>
<tr>
<td>#2</td>
<td></td>
</tr>
<tr>
<td>#3</td>
<td></td>
</tr>
</tbody>
</table>

### MENINGOCOCCAL - A,C,Y,W (eg. Menactra, Mencevax)

Dose most recently received (usually prior to undergrad college entry)

### MENINGOCOCCAL – SEROTYPE B (eg. Trumenba or Bexsero after 2015)

<table>
<thead>
<tr>
<th>Dose #</th>
<th>Date Administered</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td></td>
</tr>
<tr>
<td>#2</td>
<td></td>
</tr>
<tr>
<td>#3</td>
<td></td>
</tr>
</tbody>
</table>

- □ Bexsero
- □ Trumenba
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.

### Complete this table if student has no past history of (+) PPD or IGRA

<table>
<thead>
<tr>
<th>NO PAST HISTORY OF (+) PPD or IGRA</th>
<th>All New Admits must submit a PPD #1:</th>
<th>Given: <strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></th>
<th>Date Read: <strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong> (within 3 days of placement)</th>
<th>Induration: ________ mm**</th>
<th>Positive or Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>OR- Non-RN Students must also submit a PPD #2:</td>
<td>Given: <strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td>Date Read: <strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong> (within 3 days of placement)</td>
<td>Induration: ________ mm**</td>
<td>Positive or Negative</td>
<td></td>
</tr>
<tr>
<td>OR- All New Admits can submit an IGRA:</td>
<td>Date: <strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td>Must be completed on or after May 10, 2020</td>
<td>Positive or Negative (circle)</td>
<td>Attach lab report for verification</td>
<td></td>
</tr>
</tbody>
</table>

| If newly documented Positive, a Chest X-ray is required after Feb 10, 2020: | Date of Chest X-Ray: ________/______/______ | Results: Normal or Abnormal (circle) |

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

Student must immediately notify local health department and their VUSN Program Director.

- Treatment Started: Yes or No (circle)
- If yes, Date of Treatment: ________/______/______

### Complete this table depending on history of positive PPD or positive IGRA

<table>
<thead>
<tr>
<th>HISTORY OF POSITIVE (+) PPD or IGRA</th>
<th>(+) PPD**</th>
<th>Date of prior positive PPD: <strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></th>
<th>Induration: ________ mm**</th>
<th>Repeat PPD not needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>(+) IGRA</td>
<td>Date: <strong><strong><strong><strong>/</strong></strong><strong>/</strong></strong></strong></td>
<td>Repeat IGRA not needed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Chest X-ray required on or after Feb 10, 2020 for new admits with a previous positive:

| Date of Chest X Ray: ________/______/______ | Results: Normal or Abnormal (circle) |

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

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**

<table>
<thead>
<tr>
<th>&gt;5 mm 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>- Immigration from high prevalence area within 5 years</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 questions</td>
<td></td>
</tr>
</tbody>
</table>

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VMR 3667 (02/2020)
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.

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**Submit this health form to the Student Health Center:**
*(verification of state-mandated immunizations)*

<table>
<thead>
<tr>
<th>Step</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Since you are a new student, you will need to create an account in our student health portal at <a href="https://vanderbilt.studenthealthportal.com">https://vanderbilt.studenthealthportal.com</a>. 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.</td>
</tr>
<tr>
<td>Step 2</td>
<td>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).</td>
</tr>
<tr>
<td>Step 3</td>
<td>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.</td>
</tr>
<tr>
<td>Step 4</td>
<td>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 accepted 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.</td>
</tr>
</tbody>
</table>

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**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) 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.

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**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 (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.

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 Gallagher Student Health Insurance plan.

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.vumc.org/student-health/student-health-insurance

<table>
<thead>
<tr>
<th>1. Submit Personal Insurance to Vanderbilt University for Waiver Approval:</th>
</tr>
</thead>
</table>
| **Step 1** | Have your current health insurance ID card ready and log in to www.gallagherstudent.com/vanderbilt.  
*Note that you must do this step from May 1 - August 1.* |
| **Step 2** | Select Student Waive.  
Your user ID is your complete vanderbilt.edu email address and your password is your full Commodore ID number (located on your Student Account). Create your own unique password and continue. |
| **Step 3** | Select “I Want to Waive” (red button).  
Complete the form and review for accuracy. Upload your supporting documentation click Submit. |
| **Step 4** | You will receive a confirmation email including a confirmation number verifying that you submitted a waiver. Print a copy for your records. |
| **Step 5** | You will receive an email after your waiver has been verified for comparable coverage letting you know the status of your waiver request (most are within 24-48 hours). You can also check the status online at www.gallagherstudent.com/Vanderbilt. |

<table>
<thead>
<tr>
<th>2. Submit Insurance Coverage to Vanderbilt School of Nursing (school requirement):</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

Due by Aug. 15

| 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 (front & back) OR a letter verifying coverage.  
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.  
Documentation of the University’s student insurance (Gallagher) is made available during the first two-weeks of August for the academic year. Pull proof at: https://www.gallagherstudent.com/students/student-home.php and submit to your myCB account. |