

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

*For Office Use Only:*

MRN \_\_\_\_\_

DOB \_\_\_\_\_

Epic \_\_\_\_\_

Compliance \_\_\_\_\_

**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 GRADUATE AND POST GRADUATE STUDENTS**

Date: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ last four of SS# (part of secure VUMC medical record only) \_\_\_\_\_

Please circle: Male / Female / Other Preferred Name (if applicable) \_\_\_\_\_

International Student: Yes / No

Graduate Program Enrollment:  Divinity  Graduate  Law  MPH Public Health  
 OWEN  Peabody  Other

Term Beginning:  Spring  Summer  Fall Enrollment:  Full-Time  Part Time

Did you attend Vanderbilt for Undergraduate School:  Yes  No

**VANDERBILT MEDICAL CENTER (VUMC) & STUDENT HEALTH CENTER OUPATIENT 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/Mobile # ( ) \_\_\_\_\_

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: \_\_\_\_\_

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

**IMMUNIZATION INFORMATION**

Student's Name \_\_\_\_\_ Student's Date of Birth \_\_\_\_\_:

<b>REQUIRED STATE MANDATED IMMUNIZATIONS –</b>	<b>Date Administered (Month-Day-Year)</b>
<b>*Registration will be held if not compliant for MMR and Varicella</b> <b>*M.M.R. (MEASLES, MUMPS, RUBELLA)</b> If you were born after 1956- 2 vaccinations <b>OR</b> 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, submit positive titer results. <input type="checkbox"/> Yes, attached	#1 ____ - ____ - ____ #2 ____ - ____ - ____
<b>*VARICELLA</b> If you were born after 1980- 2 vaccinations <b>OR</b> titer results <b>OR</b> history of disease required: <ul style="list-style-type: none"> <li>Dose #1 given at age 12 months or later.....</li> <li>Dose #2 given at least 28 days after first dose.....</li> <li>Positive Titer Results <input type="checkbox"/> Yes (Official lab results must be attached)</li> <li><b>HISTORY OF DISEASE accepted for domestic/non-international students only:</b>                Date of Chicken Pox Disease (Month – Day – Year ) _____ - _____ - _____</li> </ul>	#1 ____ - ____ - ____ #2 ____ - ____ - ____  <input type="checkbox"/> Exempt (born before 1980)
<b>OTHER CDC RECOMMENDED IMMUNIZATIONS *Registration Not Held</b>	<b>Date Administered (Month-Day-Year)</b>
<b>HEPATITIS A</b> Dose #1..... Dose #2 (given 6-12 mo. after first).....	#1 ____ - ____ - ____ #2 ____ - ____ - ____
<b>HEPATITIS B</b> Dose #1..... Dose #2 (1-2 mo. after 1st)..... Dose #3 (4-6 mo. after 1st).....	#1 ____ - ____ - ____ #2 ____ - ____ - ____ #3 ____ - ____ - ____
<b>HPV</b> Dose #1..... Dose #2 (1-2 mo. after 1st)..... Dose #3 (4-6 mo. after 1st).....	#1 ____ - ____ - ____ #2 ____ - ____ - ____ #3 ____ - ____ - ____
<b>MENINGOCOCCAL – A,C,Y,W (eg. Menactra, Menveo) –</b> Dose most recently received (usually prior to undergrad college entry)	_____ - _____ - _____
<b>MENINGOCOCCAL – SEROTYPE B (eg. Trumenba or Bexsero after 2015)</b> 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 ____ - ____ - ____
<b>POLIO</b> (primary series required for all students) Date of last polio immunization.....	<input type="checkbox"/> IPV <input type="checkbox"/> OPV _____ - _____ - _____
<b>TETANUS-DIPHTHERIA-PERTUSSIS</b> Tdap (Record adolescent dose. If no adolescent dose, give Tdap booster)..... <b>AND/OR</b> Td booster (if > 10 yrs since Tdap).....	_____ - _____ - ____ _____ - _____ - ____

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**Tuberculosis Assessment – TO BE COMPLETED BY A HEALTHCARE PROVIDER**

Student's Name \_\_\_\_\_ Student's Date of Birth \_\_\_\_\_ :

TB Screening Questions:	Please Circle	
Has the student ever had a positive TB skin test?	YES	NO
Has the student recently had close contact with somebody ill with TB?	YES	NO
Has the student ever spent more than 6 weeks in Eastern Europe, Africa, Asia, Middle East or South/Central America?	YES	NO
Has the student been vaccinated with BCG?	YES	NO
Has the student been an employee or volunteer in a prison, homeless shelter, nursing home or hospital?	YES	NO
Does the student have a suppressed immune system?	YES	NO
	If YES is circled for ANY above, proceed to section below ↓	If NO is circled for ALL, proceed to page 4 →

**Provider-If student answers "YES" to any of the TB screening questions above, You must complete ONE of the tables below based on history of positive PPD or IGRA**

<b>NO PAST HISTORY OF (+) PPD or IGRA</b>	<b>PPD or IGRA required within 6 months regardless of BCG History</b>		
	PPD**	Given: ____/____/____	Date Read: ____/____/____ Induration: _____ mm** Review guidelines below Positive or Negative (circle)
	IGRA	Date: ____/____/____	Positive or Negative (circle)
	<b>IGRA will not be accepted for International students. Proceed with PPD placement if no past history of (+) PPD or IGRA.</b>		If newly documented positive, a chest x-ray is also required within the last 6 months: Date of Chest X-Ray: ____/____/____ Results: Normal or Abnormal (circle) Treatment Started: Yes or No (circle) 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		
<b>HISTORY OF POSITIVE (+) PPD or IGRA</b>	<b>Complete lines below depending on history of positive PPD or positive IGRA</b>		
	(+ ) PPD**	Date: ____/____/____	Induration: _____ mm**
	(+ ) IGRA	Date: ____/____/____	
			A chest x-ray is also required within the last 6 months: Date of Chest X-Ray: ____/____/____ Results: Normal or Abnormal (circle) Treatment Completed : Yes or No (circle) 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		

<b>**PPD Interpretation Guidelines</b>		
>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 country (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 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)

Address \_\_\_\_\_

Phone # ( ) \_\_\_\_\_

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_ Time: \_\_\_\_\_

*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 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/>

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## Immunization Compliance for Registration Instructions:

Step 1	Take this health form to your provider to have them complete & sign. <i>Our form also contains important emergency contact information and health history—therefore is preferred.</i> However, If you do not have a provider, you may submit official prior medical, state, county, or international immunization records.
Step 2	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.
Step 3	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 4	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 5	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.

### **FAQs:**

- **What if my provider wants to fax or mail my records?** This is not recommended for fastest processing, but they may do so at our fax: 615-343-0047 Attn: Immunization Compliance or mail to the Vanderbilt Student Health Center, Zerfoss Bldg, Sta. 17, F3200, Nashville, TN 37232-8710. **DO NOT SUBMIT DOCUMENTS VIA MULTIPLE METHODS.**
- **What if I am NOT compliant and I don’t have the appropriate vaccinations?** Student Health will communicate non-compliance via the student health portal secure message and inform you of next steps. Your registration hold remains until you are compliant.
- **What if I have questions:** Email [studenthealth@vumc.org](mailto:studenthealth@vumc.org) and submit your name, call back phone number and question. You may also call us at 615-322-2427. We will be happy to assist you within 24 business hours.

## 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.

Step 1	Have your current health insurance ID card ready and log in to <a href="http://www.gallagherstudent.com/vanderbilt">www.gallagherstudent.com/vanderbilt</a> . <i>Note that you must do this step from May 1 – August 1.</i>
Step 2	Select <b>Student Waive</b> . 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 <b>“I Want to Waive”</b> (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 <a href="http://www.gallagherstudent.com/Vanderbilt">www.gallagherstudent.com/Vanderbilt</a> .

For more information about Gallagher, you may contact their website at [www.gallagherstudent.com](http://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](http://www.vumc.org/student-health/student-health-insurance)