VANDERBILT UNIVERSITY SCHOOL OF NURSING
Health Questionnaire for fall 2019 & spring 2020 entries

→ ***REQUIRED***- The following demographic information from student:

Last Name _____ **Middle** _____ **First** _____

Maiden *(if applicable)*_____ **DOB** ____-____-_____ ☐ **Female** ☐ **Male** ☐ **Transgender**

Level: ☐ **MSN Pre-Specialty** ☐ **MSN Specialty**_____ ☐ **Post Master's** _____

☐ **RN** ☐ **BSN** ☐ **APN** ☐ **Other** _____ **License #**_____ **State:**_____

→ **The information** ***(above)*** **and provider signature** ***(below)*** **are required. Immunizations and testing may be documented using this form *with* authentication from health provider *(by initialing below)* OR medical and lab records can be used to meet these requirements.**
Go to: VUSN's Admitted Student webpage **for instruction on submitting the New Student Requirements & state-mandated immunizations to Student Health. Complete *VUSN* & *Student Health* requirements to register: by JULY 1st for fall enrollees** & DECEMBER 1st for spring

REQUIRED IMMUNIZATIONS / TESTS ---	**DATE ADMINISTERED (MM/DD/YR)**
1. M.M.R. (MEASLES, MUMPS, RUBELLA) (Two doses required at least 28 days apart.) **1.** Dose 1 given at age 12 months or later…… **2.** Dose 2 given at least 28 days after first dose…… **OR** TITERS- *If titer is negative, provide documentation of two MMR injections with at least one injection post negative titer result. Measles (Rubeola) titer result: ☐ Positive ☐ Negative* Date: Mumps titer result: ☐ Positive ☐ Negative* Date: Rubella titer result: ☐ Positive ☐ Negative* Date:	**#1** _____-_____-_____ **#2** _____-_____-_____ _____-_____-_____ _____-_____-_____ _____-_____-_____
2. VARICELLA **1.** Dose 1 given at age 12 months or later…… **2.** Dose 2 given at least 28 days after first dose…… **OR** POSITIVE TITER RESULT- *Not-accepted: *Hx of disease* OR *negative titer result* Varicella titer result: ☐ Positive ☐ Negative* Date:	**#1** _____-_____-_____ **#2** _____-_____-_____ _____-_____-_____
3. HEPATITIS B/ (Three doses required) **1.** Dose 1 …… **2.** Dose #2 (1-2 mo after 1st)…… **3.** Dose #3 (4-6 mo after 1st)…… **AND/OR** POSITIVE TITER RESULT Hep BsAb titer result: ☐ Positive ☐ Negative* Date: *If titer is negative, documentation of either- *three boosters* OR *one booster plus a positive titer* -required	**#1** _____-_____-_____ **#2** _____-_____-_____ **#3** _____-_____-_____ _____-_____-_____
4. TETANUS-DIPHTHERIA-PERTUSSIS (DTP/DTaP and Td/TD vaccines do not meet this requirement.) Tdap (booster received within past 10 years) ……	_____-_____-_____

5. INITIAL TWO-STEP TUBERCULIN SKIN TEST GIVEN ONE TO THREE WEEKS APART
-If both results (of 2-step) are negative, a one-step TB is required annually.

Date Administered: _____/_____/_____ Date Read: _____/_____/_____ Result: _____mm of induration

Interpretation : ☐ **Positive*** ☐ **Negative**

Date Administered: _____/_____/_____ Date Read: _____/_____/_____ Result: _____mm of induration

Interpretation : ☐ **Positive*** ☐ **Negative**

***Positive TB Skin Test/s:** medical evaluation and **documentation of a clear chest x-ray on/after May 1, 2019.**
Positive chest x-ray and/or symptoms of TB: Follow-up for medical evaluation and if needed, treatment. Provide documentation of the absence of symptoms signed by your healthcare provider. (*TB Positive Questionnaire* from student's Castle Branch account may be used.**)**
Previously positive PPD (>10 induration) or treatment for latent or active TB- Date of CXR: _____/_____/_____

Chest x-ray must be on/after May 1, 2019. Result: ☐ Normal ☐ Abnormal

To be completed by MD, DO, NP or PA:

X_____ I affirm the immunizations, titers or testing included on this form are accurate according to patient records.
(Initial to authenticate immunization and testing information above. Must be same MD, DO, NP or PA signing required statement below.)

→ ***REQUIRED- Signature for following statement:*** **I have examined this patient and feel that he/she is physically and mentally capable of carrying out assignments in a nursing school program.**

X_____ _____/_____/_____
Signature of MD, DO, NP or PA ***Date***

_____ **(**_____**)** _____-_____
Printed Name of MD, DO, NP or PA ***Phone Number of Health Provider***

_____
Address of Health Provider