

**VANDERBILT UNIVERSITY
DEMOGRAPHIC AND INSURANCE INFORMATION**

Last Name _____ First Name _____ M.I. _____

Date of Birth ____ - ____ - ____ Social Security ____ - ____ - ____

Undergraduate Graduate Law Divinity Owen Peabody

Health Care Professions: Hearing and Speech Medical Nursing

**VANDERBILT MEDICAL CENTER (VUMC) and STUDENT HEALTH CENTER OUTPATIENT
REGISTRATION INFORMATION**

Were you born at or have you even been treated at VUMC, Hospital, Clinic or ER?

YES NO If yes, under what last name (e.g. maiden)? _____

Nashville Address (if known): _____

Zip _____ Local Phone # (____) _____ Cell Phone # (____) _____

E-mail address _____

Person Responsible for Any Charges Incurred (if different from student)

Last Name _____ First Name _____

Relationship to Student _____

Street Address _____

City _____ State _____ Zip _____

Home Phone # (____) _____ Work Phone # (____) _____

SS # _____ Date of Birth _____

Occupation _____ Employer Name _____

Employer Address _____

City _____ State _____ Zip _____

EMERGENCY CONTACT

Last Name _____ First Name _____

Relationship to Student _____

Home Phone # (____) _____ Work Phone # (____) _____

Parent/Guardian Signature - Consent for Treatment of minor (Below age 18):

I authorize and consent to the routine treatment of my child by the physicians and nursing staff of the Vanderbilt University Student Health Center.

Name _____ Relationship _____
(Signature of parent/guardian)

Please return form in the envelope provided.

1. CONTINUE 

INSURANCE INFORMATION – REQUIRED

(Completion DOES NOT WAIVE the Student insurance policy)

Vanderbilt Sponsored Policy: Undergraduate Graduate International

Commercial: *Please attach a copy of both sides of your insurance card.*

Subscriber Name _____ Relationship _____

SS # _____ Date of Birth _____

Group No. _____ Policy # or ID _____

Employer _____ Plan Name _____

HMO PPO POS Indemnity Other

Mail Claim to: _____

City _____ State _____ Zip _____

Telephone # for Eligibility/Coverage (____) _____

Additional Coverage *Please attach a copy of both sides of your insurance card.*

Subscriber Name _____ Relationship _____

SS # _____ Date of Birth _____

Group No. _____ Policy # or ID _____

Employer _____ Plan Name _____

HMO PPO POS Indemnity Other

Mail Claim to: _____

City _____ State _____ Zip _____

Telephone # for Eligibility/Coverage (____) _____

Return this form to:
 Vanderbilt University
 Student Health Center
 Zerfoss Bldg., Sta. 17, SS3427B
 Nashville, TN 37232-8710
 Fax: 615-343-0047

HEALTH QUESTIONNAIRE AND IMMUNIZATION HISTORY

COMPLETION OF THE IMMUNIZATION INFORMATION ON THIS FORM IS REQUIRED FOR REGISTRATION

PART I

Last Name _____ **First Name** _____
Date of Birth ____ - ____ - ____ ***Social Security #** ____ - ____ - ____ **Male/Female/Transgender**
Undergraduate **Graduate** **Law** **Divinity** **Owen** **Peabody**
Health Care Professions: **Hearing and Speech** **Medical** **Nursing**

PART II – TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER

REQUIRED IMMUNIZATIONS	DATE ADMINISTERED (MM/DD/YR)
1. M.M.R. (MEASLES, MUMPS, RUBELLA) (required for all students) (Two doses required at least 28 days apart for students born after 1956.) 1. Dose 1 given at age 12 months or later..... 2. Dose 2 given at least 28 days after first dose.....	#1 ____ - ____ - ____ #2 ____ - ____ - ____
2. POLIO (primary series required for all students) Date of last injection	____ - ____ - ____
3. TETANUS-DIPHThERIA-PERTUSSIS (required for all students) Tdap (preferred—may be given as soon as 2 yrs after last dT booster OR dT booster within 10 yrs	____ - ____ - ____ ____ - ____ - ____
4. MENINGOCOCCAL (waiver or vaccination required for all students living on campus) Should be repeated every 3-5 yrs if risk persists (i.e. travel needs) <input type="checkbox"/> Menactra ____ - ____ - ____ OR <input type="checkbox"/> Menomune ____ - ____ - ____	
5. HEPATITIS B Health Professions: proof of immunity required (or initiation of vaccine if titer negative) All others: waiver or vaccination required Dose #1 Dose #2 (1-2 mo after 1st) Dose #3 (4-6 mo after 1st)	#1 ____ - ____ - ____ #2 ____ - ____ - ____ #3 ____ - ____ - ____
6. TITERS (required of health professions students ONLY) Rubella: <input type="checkbox"/> Positive <input type="checkbox"/> Negative ____ - ____ - ____ Varicella: <input type="checkbox"/> Positive <input type="checkbox"/> Negative ____ - ____ - ____ Hep BsAb <input type="checkbox"/> Positive <input type="checkbox"/> Negative ____ - ____ - ____	
RECOMMENDED IMMUNIZATIONS	DATE ADMINISTERED (MM/DD/YR)
1. VARICELLA 1. History of Disease <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Immunization required for health professions if titer negative, <i>recommended</i> for others with no disease history Dose #1 Dose #2 given at least 4 weeks after first	#1 ____ - ____ - ____ #2 ____ - ____ - ____
2. HEPATITIS A (strongly recommended for all students, but not required) Dose #1 Dose #2 (given 6-12 mo after first)	#1 ____ - ____ - ____ #2 ____ - ____ - ____
3. GARDASIL (recommended for females <26 years old)	#1 ____ - ____ - ____ #3 ____ - ____ - ____ #2 ____ - ____ - ____

To be completed by your Health Provider (cont.)

TUBERCULOSIS RISK SCREENING

1. Is the student a **Health Profession** student (nursing, medical, audiology) or a student at higher than average risk for tuberculosis?

High risk include: immunocompromised patients or workers in nursing homes, hospitals, prisons, or homeless shelters.

If NO , proceed to question #2

If YES , proceed to question #3

2. Has the student lived or traveled (>6 wks) in countries with a high prevalence of TB?

High prevalence TB areas include Asia, South & Central America, Africa, and Eastern Europe

If NO , no PPD is recommended (see #3 below)

If YES , PPD may be recommended (see #3 below)

3. PPD (Tuberculin Skin Test)

- History of (+) PPD? Yes No If yes, CXR within 12 months of entry is required.

CXR date ___/___/___

NORMAL ABNORMAL

- If no history of (+) PPD, please answer the following:

No PPD recommended, based on question #2 above

PPD (required within 1 year of entry) for all health professions students without history of (+) PPD. Strongly recommended for others without known (+) PPD history who answered "YES" to Questions #1 or #2

NOTE: BCG does not affect requirement.

PPD Result: Date ___/___/___ Induration _____mm

Interpretation (based on risks and induration)

POSITIVE NEGATIVE

If PPD is (+), CXR is required.

CXR Date ___/___/___

NORMAL ABNORMAL

2. CONTINUE ➡

**HEALTH HISTORY INFORMATION TO BE COMPLETED AND SIGNED BY YOUR
HEALTH CARE PROVIDER**

Student's Name _____

Student's DOB _____

Current Diagnoses or Pertinent Past Medical History:

None

1. _____
2. _____
3. _____
4. _____

Allergies

None

1. _____
2. _____
3. _____
4. _____

Current Medications:

None

1. _____
2. _____
3. _____
4. _____

The above named student is medically cleared to attend Vanderbilt University. I certify that the information on the immunization history and TB risk assessment forms are correct, to my knowledge.

Name _____

Address _____

Signature _____

Phone # () _____

Date _____

Fax # () _____