

March 2009

Dear Vanderbilt Medical Student:

Welcome to Vanderbilt University! The Student Health Center is here to help you maintain good health as you pursue your academic endeavors.

The Student Health Center (SHC) is an on-campus health care facility where all degree-seeking, registered Vanderbilt Students may receive care. The SHC provides primary care services and mental health care services similar to those that you would expect to find in a private physician's office. We encourage all students with any kind of chronic illness to make contact with us so that they can establish a primary care relationship on the Vanderbilt campus and maintain continuity of care.

All students are required to have health insurance coverage, in the event that hospitalization or care outside SHC is needed. The Gallagher Koster Insurance Company offers an insurance policy for Vanderbilt students. **The cost of the policy is automatically billed to your student account unless you submit an online waiver by August 1, 2009.** Information regarding the student insurance requirements and the waiver procedure is included on the Student Health website at [http://www.vanderbilt.edu/student\\_health/student-health-insurance](http://www.vanderbilt.edu/student_health/student-health-insurance). In early June, you will be able to go online to [www.gallagherkoster.com](http://www.gallagherkoster.com) and waive the Gallagher Koster plan if desired, and/or review further details of the plan. If the Gallagher Koster plan will be your only plan (without a backup with a family plan), you may also wish to consider purchasing the supplemental coverage, which would better protect you during a catastrophic illness or injury. The SHC has a Gallagher Koster representative onsite to personally answer any questions. The representative can be reached at (615) 343-4688, from 8 a.m.–4:30 p.m. CT, Monday through Friday.

We have several forms for you and your health care provider to fill out before your arrival on campus. The forms can be found below this letter. All health care professions students must meet requirements that are set forth by the state of Tennessee, the individual programs, and the participating hospital training sites. **If you have not met the immunization requirements before entry, the Medical School will require you to come to Student Health for completion of the requirements during orientation.** If you do NOT have insurance that will cover the required immunizations before arrival, then it may be to your financial advantage to wait until orientation. However, completion of the requirements in advance will allow you to avoid the long lines and waiting times while SHC is holding immunization clinics for all health professions students (medical, nursing, hearing and speech).

**Forms to return and complete by July 10, 2009:**

1. Demographic and Insurance Information, which includes
  - Personal contact information
  - Emergency contact information
  - Insurance information—don't forget to send a copy of your current insurance card!
  
2. Health Questionnaire and Immunization History, which includes
  - Immunization history
  - State-mandated meningococcal and Hepatitis B waiver/administration form
  - Brief health history
  - Tuberculosis screening information, signed by a health care provider for verification
  - **Though it is strongly recommended, no physical exam is required for entry, but all students must be in compliance with the requirements for health professions students.**

Please feel free to contact us with any questions or concerns before your arrival on campus. We can be reached at 615-322-2427. Our website is located at [http://www.vanderbilt.edu/student\\_health/](http://www.vanderbilt.edu/student_health/) and may be able to provide you with more insight into our services. We look forward to serving you during your years at Vanderbilt.

Sincerely,

Louise Hanson, MD  
Medical Director  
Zerfoss Student Health Center  
Vanderbilt University

(office use only) MIS \_\_\_ Star Panel \_\_\_ EPIC \_\_\_ MR# \_\_\_\_\_

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

### 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 – COMPLETION OF THE INFORMATION ON THIS FORM IS REQUIRED FOR REGISTRATION

REQUIRED IMMUNIZATIONS	DATE ADMINISTERED(MM/DD/YR)
1. TETANUS-DIPHThERIA-PERTUSSIS (required for all students) <b>dT booster within 10 yrs</b> ..... OR <b>Tdap (preferred—may be given as soon as 2 yrs after last dT booster)</b>	_____ - _____ - _____ OR _____ - _____ - _____
2. HEPATITIS B Health Professions: proof of immunity required (or initiation of vaccine if titer negative) All others: waiver or vaccination required <b>Dose #1</b> ..... <b>Dose #2 (1-2 mo after 1<sup>st</sup>)</b> ..... <b>Dose #3 (4-6 mo after 1<sup>st</sup>)</b> .....	<b>#1</b> _____ - _____ - _____ <b>#2</b> _____ - _____ - _____ <b>#3</b> _____ - _____ - _____
3. 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.....	<b>#1</b> _____ - _____ - _____ <b>#2</b> _____ - _____ - _____
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"/> <b>Menactra</b> _____ - _____ - _____ OR <input type="checkbox"/> <b>Menomune</b> _____ - _____ - _____
5. POLIO (primary series required for all students) <b>Date of last injection</b> .....	_____ - _____ - _____ <input type="checkbox"/> <b>IPV</b> <input type="checkbox"/> <b>OPV</b>
6. TITERS (required of health professions students ONLY) <b>Rubella:</b> <input type="checkbox"/> <b>Positive</b> <input type="checkbox"/> <b>Negative</b> _____ - _____ - _____ <b>Varicella:</b> <input type="checkbox"/> <b>Positive</b> <input type="checkbox"/> <b>Negative</b> _____ - _____ - _____ <b>Hep BsAb</b> <input type="checkbox"/> <b>Positive</b> <input type="checkbox"/> <b>Negative</b> _____ - _____ - _____	
RECOMMENDED IMMUNIZATIONS	DATE ADMINISTERE(MM/DD/YR)
1. HPV (recommended for females <26 years old)	<b>#1</b> _____ - _____ - _____ <b>#2</b> _____ - _____ - _____ <b>#3</b> _____ - _____ - _____
2. HEPATITIS A (strongly recommended for all students, but not required) <b>Dose #1</b> ..... <b>Dose #2 (given 6-12 mo after first)</b> .....	<b>#1</b> _____ - _____ - _____ <b>#2</b> _____ - _____ - _____
3. 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 <b>Dose #1</b> ..... <b>Dose #2 given at least 4 weeks after first</b> .....	<b>#1</b> _____ - _____ - _____ <b>#2</b> _____ - _____ - _____

**1. CONTINUE**

# HEALTH HISTORY INFORMATION and TB SCREENING QUESTIONNAIRE

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

**Current Weight:** \_\_\_\_\_

**Current Diagnoses or Pertinent Past Medical History:**

None

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ |          |

**Allergies:**

None

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

**Current Medications:**

None

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

**Tuberculosis (TB) Screening Questions:**

- |   |  |
|---|--|
| 1. Have you ever had a positive TB skin test?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have you ever had close contact with somebody ill with TB?                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Were you born in Africa, East Europe, Asia, Middle East, or South/Central America?               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Have you traveled to the areas listed above?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Have you been vaccinated with BCG?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Have you been an employee or volunteer in a prison, nursing home, homeless shelter, or hospital? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Are you an entering student in the school of Medicine, Nursing or Hearing and Speech?            | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If the answer to all of the above questions is NO, then proceed to page #4.

If you answered yes to any of the questions above, then you will need to proceed to page #3 of the health questionnaire and have your health care provider complete the tuberculosis risk assessment.

**I certify that the health and immunization information that I have provided Vanderbilt University is accurate and represents my health status at the time of completion of this form. I have confirmed my immunization history with my health care provider or from my certified personal copies of immunization records.**

Name \_\_\_\_\_ (Printed name of student or parent/guardian if student under age 18)

**Signature** \_\_\_\_\_ (Signature of student or parent/guardian if student under age 18)

Date \_\_\_\_\_

**TUBERCULOSIS RISK ASSESSMENT**  
**MUST BE COMPLETED AND SIGNED BY A HEALTHCARE PROVIDER IF ANY ANSWER ON THE SCREENING QUESTIONNAIRE (ON PAGE 2) IS "YES"**

Student's Name \_\_\_\_\_ Student's DOB \_\_\_\_\_

Persons with any of the following risk factors are candidates for either a TB skin test (PPD) or Interferon Gamma Release Assay (IGRA), UNLESS a previous positive test has been documented.

Please answer the following additional TB risk screening questions (see also the prior page):

1. Does the student have HIV/AIDS?  Yes  No
2. Organ transplant recipient?  Yes  No
3. Immunosuppression (equiv to 15 mg prednisone or TNF-alpha antag)?  Yes  No
4. History of illicit drug use?  Yes  No
5. Chronic illness that may increase risk for TB progression (diabetes, silicosis, cancer, renal disease, malabsorption, or intestinal bypass)?  Yes  No

**TB Risk Assessment**

1. **Does the student have signs or symptoms of active TB?**  Yes  No

*If no, then proceed to #2. If YES, then proceed with further evaluation as indicated.*

2. **Medical assessment**

- a. **Has +PPD been noted previously?**  Yes  No

➤ *If yes, then chest x-ray is required within 6 months of entry:*

Date of CXR \_\_\_/\_\_\_/\_\_\_

Result  Normal  Abnormal

➤ *If yes, has the patient completed a 9 mo course of INH?*

Yes, completed \_\_\_/\_\_\_/\_\_\_

No

- b. **PPD (or IGRA) must be done if there is no history of previous positive PPD or IGRA. The PPD should be recorded as actual millimeters of induration and interpreted based on the guidelines (\*\*\*) below.**

Date Read: \_\_\_/\_\_\_/\_\_\_

Result: \_\_\_\_\_ mm of induration

\*\*Interpretation (see guidelines below):

Positive  Negative

- c. **Interferon Gamma Release Assay (IGRA)—required only if PPD was not done**

Date obtained: \_\_\_/\_\_\_/\_\_\_

Method:  QFT-G  QFT-GIT  Other \_\_\_\_\_

Result:  Positive  Negative  Intermediate

*If the IGRA is POSITIVE, then chest x-ray is required within 6 months of entry:*

Date of CXR \_\_\_/\_\_\_/\_\_\_

Result  Normal  Abnormal

**\*\*Interpretation Guidelines**

**> 5 mm is positive:**

Recent close contact with person with active TB  
 Abnormal CXR c/w past TB disease  
 Organ transplant or other immunosuppression  
 HIV/AIDS

**>10 mm is positive:**

Significant travel or residence in high prevalence area  
 Illicit drug use  
 Worker in healthcare, homeless shelter, prisons  
 Chronic health issues, as per above screening questions

**>15 mm is positive if no risk factors**

**HEALTH CARE PROVIDER SIGNATURE REQUIRED:**

Printed Name \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number \_\_\_\_\_

**3. CONTINUE** ➡

**VANDERBILT UNIVERSITY  
DEMOGRAPHIC AND INSURANCE INFORMATION**

Date Form Completed: \_\_\_\_\_

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 VU Medical Center, Hospital, Clinic or ED?  YES  NO

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

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

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)

**4. CONTINUE** ➡

**HEALTH INSURANCE INFORMATION – REQUIRED**

(Completion DOES NOT WAIVE the student health insurance policy)

Vanderbilt Sponsored Insurance Policy:  Undergraduate  Graduate  International

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

Subscriber Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_

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 to Student \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_

Group No. \_\_\_\_\_ Policy # or ID \_\_\_\_\_

Employer \_\_\_\_\_ Plan Name \_\_\_\_\_

HMO  PPO  POS  Indemnity  Other

Mail Claim to: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone # for Eligibility/Coverage (\_\_\_\_) \_\_\_\_\_

