

(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 ADMINISTERED(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 (\_\_\_\_) \_\_\_\_\_

