

HEALTH SCREENING FORM FOR VU STUDENT OBSERVERS

Name: _____ Date of Birth: ____/____/____ SSN: _____

Shadowing Start Date: 9/1/2023 Shadowing End Date: 12/7/2023 (Fall 2023 Semester)

Sponsor*: **VU HEALTH PROFESSIONS ADVISORY OFFICE** Sponsor's email: **hpao@vanderbilt.edu**

**The sponsor is the contact person in the host department who is accountable to ensure the visitor's compliance.*

Visiting Research Intern (HR record) Observer

THIS SECTION TO BE COMPLETED BY HEALTHCARE PROVIDER (NOT WORKER/VISITOR/VISITING STUDENT)

INITIAL ONE OPTION IN EACH SECTION & **PROVIDE DATES** WHERE INDICATED ("See attached" is NOT ACCEPTED)



MEASLES, MUMPS AND RUBELLA

___ Two (2) doses of MMR vaccine after first birthday (vaccine dates: _____, _____)
 ___ Serologic proof of immunity to measles, mumps and rubella (positive IgG antibody)
 (Lab dates: Measles _____ Mumps _____ Rubella _____)
 ___ Pt born prior to 1957 and has positive immunity to rubella (lab date: _____)

VARICELLA

___ Documented serologic immunity to varicella (positive IgG antibody date: _____)
 ___ Two (2) doses of varicella vaccine (vaccine dates: _____, _____)

HEPATITIS B

___ Two (2) or Three (3) doses of hepatitis B vaccines _____
 ___ Serologic Proof of Immunity (positive Hep B surface Antibody) _____ (*lab 4-8 weeks after vaccination is recommended)
 ___ Wishes to decline vaccine.

TUBERCULOSIS

If TB skin test or IGRA **positive**:
 ___ Chest X-ray has no evidence of active TB **AND** Treatment for latent TB infection was offered
 X-ray date (must be more recent than 6 months before Start Date): _____
 If TB skin test or IGRA **negative**: (*note: if stay will be < 2 weeks, only 1 TST within 3 months of start date is required).
 ___ Two step TB testing completed with **NEGATIVE** results
 Date of 1st TBST (must be within 1 year of start date): _____
 Date of 2nd TBST (must be more recent than 3 months before start date): _____
 ___ IGRA completed more recently than 3 months before start date. IGRA date: _____

INFLUENZA (only applicable if individual will be on VUMC campus for any day between Oct 1 and Mar 31)

___ Date of annual influenza vaccine (must be between Jul 1 & Mar 31 of current flu season): _____ Future Flulapalooza
(Proof Required Before Starting)

PERTUSSIS(required in pediatric, emergency, and women's health depart. or "assignment pending/uncertain" status)

___ One dose of Tdap vaccine (NOTE: DTP/DTaP and Td/TD vaccines do not meet this requirement.) Date: _____

COVID-19 (Full series of an FDA/WHO-approved COVID-19 vaccine)

___ Brand: _____ Vaccine dates: _____ booster date(s) (if applicable) _____

I attest that I have reviewed official documentation for all vaccines, X-rays, and lab tests marked above and that the information is complete and accurate to the best of my knowledge: (note: VUMC may, at its discretion, request additional/clarifying information if needed)

Healthcare Provider Printed Name _____ Date _____
 Healthcare Provider Signature _____
 Office Address _____ Phone Number (____) _____



THIS SECTION TO BE COMPLETED BY CONTRACTED WORKER/VISITOR/VISITING STUDENT:

I have received and reviewed the educational materials related to blood borne pathogens as required by OSHA.

Contract Worker/Visitor/Visiting Student

Date