REQUIRED ADDITIONAL IMMUNIZATIONS

Vanderbilt University School of Medicine

224 Eskind Biomedical Library, Nashville TN 37240

PART I – TO BE COMPLETED BY THE STUDENT

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First MI

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prior rotations at VUMC?: □No □Yes Date of 1st rotation at VUMC: \_\_\_\_\_\_\_\_\_\_\_\_

PART II – TO BE COMPLETED AND SIGNED BY A LICENSED HEALTHCARE PROVIDER

1. Influenza Vaccine (in current flu season if rotating September 1-March 31): Date: \_\_\_\_\_\_\_\_\_\_\_\_
2. Tuberculosis Screening: Must provide proof of a 2 step-PPD or IGRA since starting Medical School:

Admission to Medical School: Month/Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of ANY 2 Step since starting Medical School:

PPD #1 Date \_\_\_\_\_\_\_\_\_\_ □Positive □Negative

PPD #2 Date \_\_\_\_\_\_\_\_\_\_ □Positive □Negative

OR

IGRA Date\_\_\_\_\_\_\_\_\_\_\_ □Positive □Negative

\*\*If a 2 step PPD or IGRA has not been completed since starting medical school, this requirement will be met by having one negative PPD within one year of the rotation, and a second negative PPD within 3 months of the rotation OR an IGRA within 3 months of the rotation\*\*

PPD within 1 year of rotation Date \_\_\_\_\_\_\_\_\_\_\_\_ □Positive □Negative

PPD within 3 months of rotation Date \_\_\_\_\_\_\_\_\_\_\_\_ □Positive □Negative

OR

IGRA within 3 months of rotation Date \_\_\_\_\_\_\_\_\_\_\_\_ □Positive □Negative

\*\*Complete the section below if there is a history of a POSITIVE IGRA or POSITIVE PPD:

History of (+) PPD or IGRA? □Yes Date: \_\_\_\_\_\_\_\_

If yes, treatment completed? □Yes □No If no, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, chest x-ray required to be within 6 months of rotation: Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, must complete Vanderbilt TB symptom Screen within 6 months of rotation: □ Attached

HEALTH CARE PROVIDER

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Printed)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_