

HEALTH SCREENING FORM FOR VU STUDENT OBSERVERS

Name: _____ Date of Birth: ____/____/____ SSN (Last 4 Digits): _____

Shadowing Start Date: 5/15/2024 Shadowing End Date: 8/20/2024 (Summer 2024 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
Three (3) doses of hepatitis B vaccines* _____ OR Two (2) doses of Heplisav brand
hepatitis B vaccines (given to those 18+): _____
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): _____
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 _____