The UNIVERSITY of VERMONT
College of Nursing and Health Sciences

PRE-CLINICAL MANDATORIES

Program:_____

Student Name: _____ Date of Birth: ____/_____/_____ Cell phone#: (____)_____-_____
Last Name First Name Middle Initial mm dd yr

Part 1: Everything must be filled out by your licensed health care provider on this UVM form ONLY. Copies of Medical Records/Labs will NOT be accepted.

VACCINE NAME	DATES OF VACCINATION	OR DATES OF POSITIVE TITERS (BLOOD TEST) OR DISEASE HISTORY
TDAP Tdap in last 10 yrs. If you have not had a Tdap and your last Td is more than two yrs. a Tdap is required. (Do not receive a Td booster.)	Tdap Date: _____/_____/_____ mm dd yr	*Not applicable*
HEPATITIS B *Dose at 0, 1 and 4 mos from 1st dose *Titer 1 - 2 months after 3rd dose *Healthcare provider initial each dose	#1: _____/_____/_____ _____ mm dd yr (initials) #2: _____/_____/_____ _____ mm dd yr (initials) #3: _____/_____/_____ _____ mm dd yr (initials) **(Titer required with 3 doses)** → →	**Surface Antibody Titer (Circle One):** Positive or Negative Date: _____/_____/_____ mm dd yr **(Titer required with 3 doses)**
MMR (Measles, Mumps, Rubella) *2 doses of MMR vaccine *First dose must be after 1st birthday *Minimum 4 wks between doses	#1_____/_____/_____ mm dd yr #2_____/_____/_____ mm dd yr **(No titer required if two doses were given)**	**Pos. Measles Titer:** _____/_____/_____ mm dd yr **Pos. Mumps Titer:** _____/_____/_____ mm dd yr **Pos. Rubella Titer:** _____/_____/_____ mm dd yr
VARICELLA (CHICKEN POX) *2 doses of Varicella vaccine *Minimum 4 wks between doses **Titer required with history of disease.	#1_____/_____/_____ mm dd yr #2_____/_____/_____ mm dd yr **(No titer required if two doses were given)**	Disease History: _____/_____/_____ (if documented) mm dd yr **AND** **Positive Varicella Titer:**_____/_____/_____ mm dd yr

HEALTH CARE PROVIDER'S SIGNATURE (Required): I certifiy that this student has received the immunizations or has laboratory evidence of immunity as indicated on this page.

_____ _____ _____
Signature and Credentials Printed Name Date

_____ _____
Office phone number Office Fax Number

The information included on this form may be released to the infection control officer and clinical education coordinators at sites where you perform your clinical education experience.

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COLLEGE OF NURSING & HEALTH SCIENCES

Name _____
Date of Birth _____
Program/Graduation Year _____

TWO-STEP PPD REQUIREMENTS

COPIES OF MEDICAL RECORDS/LABS WILL NOT BE ACCEPTED.

2 Step PPD - Tuberculin Skin Test - BCG vaccine does not preclude the need for PPD testing or chest x-ray.

Timeline: PPD placed, then read 48 hours following placement.
Per CDC guidelines, placement of 2nd PPD should be 1-3 weeks after first PPD is read. 2nd PPD should be read 48 hours following placement.

1) Date given: _____ Date read: _____ Results (mm): _____

circle result **:** pos neg

2) Date given: _____ Date read: _____ Results (mm): _____

circle result **:** pos neg

OR Tuberculin Blood Test

1) Date given: _____ ***Circle result*** **:** pos neg

IF FIRST TIME WITH A POSITIVE PPD: Please attach copy of radiology report, and list results.

IF HISTORY OF A POSITIVE PPD:
1) Print the TB Symptom Checklist
2) Take the TB Symptom Checklist to your appointment and give to your health care provider to complete

**Please note, depending on your site placement, a chest x-ray and/or annual TB symptom checks may also be required if you have a history of a positive PPD.*

Licensed Health Care Provider Attestation

By signing below, I affirm that I am a licensed health care provider. I am aware that leaving any required fields blank will result in the student being **unable to progress** **in his/her major** at the University of Vermont.

_____ _____ _____
Signature of **Licensed Health Care Provider** **Credentials** Date

_____ _____
Clinic Stamp or Printed Name of Provider Provider Telephone Number

Submit Form To CastleBranch after both tests are completed.

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Name _____
Student ID# _____
Date of Birth _____
Program/Graduation Yr _____

THIS FORM IS TO BE COMPLETED BY YOUR LICENSED HEALTHCARE PROVIDER ONLY IF YOU HAVE A NEGATIVE OR INDETERMINATE HEPATITIS B TITER. COPIES OF MEDICAL RECORDS/LABS WILL NOT BE ACCEPTED.

HEPATITIS B BOOSTER AND HEPATITIS B SECOND SERIES FORM

Hepatitis B Booster AND 2nd Titer Required

Booster Date: _____ Initials: _____ (Dose #4)

Titer #2 (1 - 2 months after booster) Date: _____ Initials: _____

Circle result: *Positive* *Negative* *Indeterminate*

****IMPORTANT: If your booster titer result above is negative or indeterminate, you are required to repeat the full series of Hepatitis B doses and titer. Heplisav-B vaccine series is accepted. See below:**

Hepatitis B (Complete this only if titer above is negative or indeterminate)

☐ Engerix
☐ Twinrix (Hep A & B)

Dose #5 date: _____ Initials: _____

Dose #6 date: _____ Initials: _____

Timeline for doses: Get 4th dose, get 5th dose 1 month later, get 6th dose 4 months from 4th dose; Get titer 1 to 2 months after 6th dose.

Healthcare provider: If Engerix or Twinrix is used, please note on Dose 4 (booster), 5 and 6.

OR

Hepatitis B (Complete this only if titer above is negative or indeterminate)

☐ Heplisav

Dose #5 date: _____ Initials: _____

Timeline for doses: Get 4th dose, get 5th dose 1 month later, get titer 1 to 2 months after 5th dose.

Healthcare provider: If Heplisav-B is used, please note on Dose 4 (booster) and 5.

3RD TITER (Required after either series above)

Date: _____

Circle result: positive negative indeterminate

Health Care Provider Initials: _____

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Signature of **Licensed Health Care Provider** **Credentials** Date

Clinic Stamp or Printed Name of Provider Provider Telephone Number

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