



PRE-CLINICAL MANDATORIES

College of Nursing and Health Sciences

Program: \_\_\_\_\_

To be completed by a licensed health care provider. Copies of medical records/labs will not be accepted.

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.

Table with 3 columns: VACCINE NAME, DATES OF VACCINATION, and OR DATES OF POSITIVE TITERS (BLOOD TEST) OR DISEASE HISTORY. Rows include MMR (Measles, Mumps, Rubella), VARICELLA (CHICKEN POX), TDAP- Tdap in last 10 yrs., and HEPATITIS B.

HEALTH CARE PROVIDER'S SIGNATURE (Required): I certify 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



Name \_\_\_\_\_  
 Student ID# \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Program/Graduation Yr \_\_\_\_\_

COLLEGE OF NURSING & HEALTH SCIENCES

**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: \_\_\_\_\_ Titer #2 (1-2 months after booster) Date: \_\_\_\_\_ Initials: \_\_\_\_\_  
 (Dose #4)

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)					3RD TITER	
	<b>Date</b>	<b>Initials</b>	<b>OR</b>	<b>Date</b>	<b>Initials</b>	
			Twinrix (Hep A&B)			
Dose #5 date:	_____		Dose #5 date:	_____		Date and result of lab titer: _____
Dose #6 date:	_____		Dose #6 date:	_____		Hep B Surface Ab date: _____
<p>Timeline for doses: Receive 4th (booster) dose, 1-2 months after dose receive 2nd titer. If negative receive 5th dose. Receive 6th dose, 4 months from 4th (booster) dose; Receive titer 1 to 2 months after 4th (booster) dose. If results are negative and indeterminate please counsel for prevention precautions.</p> <p>Healthcare provider: If Heplisav-B is used, please note on Dose 4 and 5.</p>						<p><b>Circle result:</b> positive negative indeterminate</p> <p>Health Care Provider Initials: _____</p>

**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

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



Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Program/Graduation Year \_\_\_\_\_

COLLEGE OF NURSING & HEALTH SCIENCES

**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.

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**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.*

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\_\_\_\_\_  
 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.**

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