



The  
**UNIVERSITY**  
of **VERMONT**

COLLEGE OF NURSING & HEALTH SCIENCES

Name \_\_\_\_\_  
 Student ID# \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Program/Graduation Year \_\_\_\_\_  
 Phone # \_\_\_\_\_  
 Email \_\_\_\_\_  
 Date \_\_\_\_\_

**Tdap PRE-CLINICAL REQUIREMENT**

**Everything MUST be ENTIRELY filled out by your licensed health care provider on this UVM-provided form ONLY.**

**It is your responsibility to make sure your physician completes this form properly.**

**COPIES OF MEDICAL RECORDS/LABS WILL NOT BE ACCEPTED.**

**CNHS doesn't cover the cost of immunizations/serology. If you visit Student Health, you can file your receipt with the insurance company to see if you can get reimbursed.**

**Tetanus - Diphtheria - Pertussis (Tdap)**

*\*If you have not had a Tdap and your last Td is more than two years old, you are required to have a Tdap.*

*\*\*Tdap must be within 10 years.*

*\*\*\* Do not receive a regular TD Booster! Request that your Primary Care Provider give you a Tdap.*

Date of Tdap: \_\_\_\_\_

**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

**It is MANDATORY that you scan and upload ALL Pages of the form to CastleBranch.  
DO NOT SEPARATE PAGES.**

Please note, UVM Student Health will not submit your paperwork for you. You will need to pick up your documents and submit them to CastleBranch.

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.