The following document may be completed by a physician's office or yourself to ensure that all required vaccines have been received. Please carefully read the descriptions noting any specific details for vaccines.

If completed by a physician's office, it MUST be signed and stamped by the office.

If completed by yourself, it MUST be accompanied by an official vaccination record noting the dates and names of the immunizations.

Once completed, you will need to enter the dates on the health portal using the IMMUNIZATION tab. Additionally, you will need to upload this document and any supporting records (immunization records or lab work) to the health portal using the UPLOAD tab. Please note these steps MUST be completed in a specific order for successful submission in the health portal.

In addition to the immunization date entry and upload requirements, the Medical History and Student Consent for Treatment forms must be completed on your health portal.

You can find printable step by step instructions on the health portal on the FORMS tab. Please feel free to contact our office by email or phone with any questions.

Belmont University Health Services
1900 Belmont Blvd
Nashville TN 37212
McWhorter Rm 106
615-460-5506
Healthservices@belmont.edu

Belmont University Immunization Form

Name: ______________________________________ Date of birth (MM/DD/YYYY) ___________
(Last) (First) (MI)

BUID: ___________________________ Cell Number: (____) ____-______

Will you be living in on-campus housing? (circle one): YES NO
Students living in on campus, please note the Meningitis ACWY requirement.

Major (circle): Nursing Medicine Pharmacy Physical Therapy Occupational Therapy Other

INSTRUCTIONS: This <u>document WILL NOT be accepted without the health care provider's signature and office stamp in the appropriate space or a copy of medical records with evidence of immunizations must be provided.</u> After completing, student must enter dates in health portal under IMMUNIZATION then upload this document and any supporting documentation such as lab reports for titers to the health portal on the UPLOAD tab.

Belmont University Immunization Requirements

Vaccine	Notations	Date of Dose
Measles, Mumps & Rubella (M-M-R®, Priorix®, ProQuad®)	**REQUIRED:** Students born on or after January 1, 1957, must provide proof of immunization with two (2) doses of MMR vaccine at least 28 days apart. **OR** positive blood titer for antibodies showing immunity to MMR. *Note: **Positive titer result REQUIRED** for Nursing, Pharmacy and Medical Students prior to clinical rotations.	Dose 1_________ Dose 2_________ Date of Positive Titer Results: _______________ (attach lab report)
Varicella (Varivax®, ProQuad®)	**REQUIRED:** All students born on or after January 1, 1980, must provide proof of immunization with two doses of Varicella vaccine at least 28 days apart. **OR** documentation from a medical provider verifying a previous diagnosis of chickenpox (supporting documentation must be uploaded.) **OR** positive blood titer for antibodies showing immunity to Varicella. *Note: **Positive titer result REQUIRED** for Nursing, Pharmacy and Medical Students prior to clinical rotations.	Dose 1__________ Dose 2__________ Date of Illness (at least year): _______________ Date of Positive Titer Result: _______________ (attach lab report)
Meningitis ACWY (MCV4,Menveo®, MenQuadfi®, PENBRAYA)	**REQUIRED for students living in on-campus housing:** **RECOMMENDED for all other students:** Students living in campus housing must provide proof of receiving a dose of quadrivalent conjugate vaccine (MCV4 protects against strains ACYW) **at greater than or equal to 16 years of age**.	Date of Dose **at age 16 or older:** _______________ **NOTE: dose MUST be after age 16.**
Tetanus-diptheria-pertussis	**RECOMMENDED:** One (1) dose of Tdap and if last Tdap is more than 10 years old, a booster dose of Tdap or Td.	TdaP: __________ Tetanus: ________

(Tdap, Adacel® or Boostrix®)	*Note: **TDAP REQUIRED** within the past ten years for Nursing, Pharmacy, Medical, Occupational Therapy and Physical Therapy Students prior to clinical rotations.	**NOTE: One dose MUST be within last 10 years**
Hepatitis B (3 doses of Energix-B® or Recombivax-HB® OR 2 doses of Heplisav-B®)	**RECOMMENDED:** Completed 2-dose or 3-doses series of Hepatitis B vaccine. **OR** positive blood titer for antibodies showing immunity to Hepatitis B. *Note: **Positive titer result REQUIRED** for Nursing, Pharmacy and Medical Students prior to clinical rotations. **Completed series of vaccines OR Positive titer result REQUIRED** for PT and OT Students prior to clinical rotations.	Dose 1 ___________ Dose 2___________ Dose 3___________ Date of Positive Titer Results: ______________ (attach lab report)
COVID-19	**RECOMMENDED:** One (1) dose of updated COVID-19 vaccine. *Note: **COVID-19 vaccine may be required by some clinical sites** for Nursing, Pharmacy, Medical, Occupational Therapy and Physical Therapy Students.	Last Dose:___________ Brand/type:___________
Influenza	**RECOMMENDED:** Seasonal flu vaccine. *Note: Check with college for **Flu vaccine requirement dates** for Nursing, Pharmacy, Medical, Occupational Therapy and Physical Therapy Students.	Last Dose:___________
Hepatitis A (2 Doses)	**RECOMMENDED:** Completed 2-dose series of Hepatitis A vaccine.	Dose 1_________ Dose 2_________
Meningococcal Serogroup B (Bexsero®, Trumemba®, PENBRYA)	**RECOMMENDED:** Completed 2-dose series of Meningitis B vaccine. .	Dose 1_________ Dose 2_________
Polio primary series or Adult Booster	**RECOMMENDED:** Completed childhood series of Polio vaccine or Adult Polio booster.	Date of completed primary series ______________ or Adult Booster:_________________
Human Papillomavirus (HPV)	**RECOMMENDED:** Completed 2-dose or 3-dose series of HPV vaccine.	Dose 1 ___________ Dose 2___________ Dose 3___________

TB Skin Test (PPD) Screening Questions:

1. Have you ever had a positive TB test or diagnosed with Tuberculosis? **If "yes" you must attach/upload a chest x-ray or proof of treatment.**
2. Have you been in close contact with someone with tuberculosis?
3. Were you born in Africa, Eastern Europe, Asia, the Middle East, or South/Central America?
4. Have you had extended or frequent travel to the areas listed above?
5. Have you been an employee or volunteer in a prison, nursing home, homeless shelter, or hospital?

If you answered “yes” to one or more of questions 2.-5. above, please provide documentation of a TB skin test and results performed within last 12 months. *Check with college for **TB test requirement** for Nursing, Pharmacy, Medical, OT & PT.

TB Skin Test: Date placed____________ Arm RT/LT (circle) Date read:___________ Result:____mm

HEALTH CARE PROVIDER CERTIFICATION:

THIS MUST BE SIGNED AND STAMPED BY THE PROVIDER or DESIGNEE

PROVIDER NAME (Print): _______________________ADDRESS: _______________________

PROVIDER SIGNATURE: _______________________PROVIDER STAMP:

PHONE: ________________________