



MACON & JOAN BROCK
VIRGINIA HEALTH SCIENCES
AT OLD DOMINION UNIVERSITY

To: Incoming Visiting Student

RE: Health Requirements for Visiting Student at Macon & Joan Brock Virginia Health Sciences at Old Dominion University

Macon & Joan Brock Virginia Health Sciences at Old Dominion University adheres to the Centers for Disease Control (CDC) guidelines regarding immunization of health-care workers. You must provide copies of immunization documentation (i.e., shot records), laboratory reports indicating immunity, and documentation of placement, read and results of tuberculin skin tests or chest x-ray reports if previously tuberculin skin test positive.

Copies of immunization records, laboratory reports, and radiology report MUST be included with this form. If you do not have immunization records, you must have antibody titers drawn to prove immunity to measles, mumps, rubella, and varicella and provide Macon & Joan Brock Virginia Health Sciences at Old Dominion University with copies of lab reports.

Visiting students are responsible for the cost of immunizations, laboratory tests, and/or chest x-rays.

Full Name: _____ M/F (Circle One)

Previous Legal Name: _____ (must provide legal documentation showing proof of previously used name)

Date of Birth: ____ / ____ / ____ SSN: XXX/XX/ ____ (last four)

Home Phone Number: (____) _____ - _____ Cell Number: (____) _____ - _____

E-Mail Address: _____

Dates of Rotation at Macon & Joan Brock Virginia Health Sciences at Old Dominion University:

____ / ____ / ____ TO ____ / ____ / ____

The following are requirements for visiting students:

1. Tuberculosis:
 - A. You are required to provide documentation of an Interferon Gamma Release Assay (IGRA) blood test (either Quantiferon Gold or T-Spot) within (6) months of the clinical rotation start date.
Date: ____/____/____ Result: _____
 - B. If you have had a **previous positive TB test**, attach a copy of a chest x-ray report done within the past year **AND** physician documentation regarding treatment dates with antibiotic therapy or why treatment was contraindicated. Please contact Occupational Health to obtain a Tuberculosis Symptom Surveillance Questionnaire that must also be completed.
Date of positive TB test: ____/____/____ Date of CXR: ____/____/____
Result of CXR: _____
Date of treatment: ____/____/____ Length of Treatment: _____



MACON & JOAN BROCK
VIRGINIA HEALTH SCIENCES
AT OLD DOMINION UNIVERSITY

2. Measles, Mumps, Rubella (MMR) immunity: attach documentation of two doses of live MMR vaccine if you were born in or after 1957 or copies of measles, mumps, and rubella IgG antibody titers indicating immunity.

MMR #1: ___/___/___ MMR #2: ___/___/___

Dates & Results of Measles Mumps Rubella Titers: ___/___/___ Results: _____

3. Varicella immunity: attach documentation of two doses of Varicella vaccine or a copy of a varicella IgG antibody titer indicating immunity:

Varicella #1: ___/___/___ Varicella #2: ___/___/___

Date & Result of Varicella Titer: ___/___/___ Result: _____

4. Tetanus/Diphtheria/Pertussis (Tdap): attach documentation of a Tdap immunization after age 11. If Tdap was given greater than 10 years prior to the rotation start date, must also attach documentation of a Tetanus-diphtheria (Td) or Tdap booster immunization given less than 10 years prior to the rotation start date.

NOTE: (Tdap and Td are not the same immunization)

Tdap: ___/___/___ Td: ___/___/___

5. Hepatitis B: If you have had the Hepatitis B vaccine series, attach documentation of the dates of the three doses (optional). Attached required documentation of a Hepatitis B surface antibody titer (**Quantitative only**) indicating immunity.

Hep B #1: ___/___/___ Hep B #2: ___/___/___ Hep B #3: ___/___/___

Date & Result of Hep B Surface Antibody Titer (**Quantitative only**):

___/___/___ Result: _____

6. Influenza: attach documentation of proof of influenza vaccine for current influenza season.

Influenza: ___/___/___

7. COVID-19: attach documentation of proof of an approved FDA COVID vaccine series.

COVID #1: ___/___/___ COVID #2: ___/___/___ Brand: _____

****This is an optional requirement*****

8. Do you have any food or medication allergies? If yes, please list.

If you have any questions regarding these mandatory health requirements, please call Occupational Health at (757)446-5870 or email at VHS-OccHealth@odu.edu