UNIVERSITY of VIRGINIA | Department of Student Health

Entire form due August 31, 2017 for Fall or January 31, 2018 for Spring to avoid $100 processing fee.

Fall 2017 and Spring 2018

Dear New University of Virginia Student:

The staff of Elson Student Health wishes to congratulate you on your acceptance to the University! Our staff are here both to help you maintain a foundation of good health and to help restore your health in the event of illness, injury, or stress. Building immunity to common communicable diseases is a critical first step in protecting your health and that of your fellow students. Completion of the Pre-entrance Health Form on the following pages allows you to demonstrate that you have met the basic immunization requirements known to promote a healthy campus community.

Your health care provider must complete and sign this form. The form may be submitted by mail, fax, e-mail or dropped off at Student Health:

Department of Student Health
University of Virginia
P. O. Box 800760
400 Brandon Avenue, Room 142
Charlottesville, VA 22908-0760
Phone: (434) 924-1525; FAX: (434) 982-4262
Website: http://www.virginia.edu/studenthealth
Email: sth-mr@virginia.edu

The form can also be submitted via our secure patient portal: https://www.healthyhoos.virginia.edu (requires NetBadge account). Click on "Upload" and follow the instructions.

Please ensure you have completed all **required** sections listed below prior to submission. **Students with forms received after August 31, 2017 (January 31, 2018 for the spring semester) will be subject to a $100.00 late fee.** The secure patient portal (https://www.healthyhoos.virginia.edu) is where you may verify receipt of the form (allow 5 working days for data entry after anticipated receipt date) and view immunization data in case you are contacted about any deficiencies. You will be notified of any incomplete requirements by secure message on the patient portal.

Please note:

1. **Designated Emergency Contact(s):** Parent, guardian, spouse, or next-of-kin who could be of support to you, or assist with medical decision making in the event you are unable to speak for yourself.
2. **Long-Term Signature Agreement:** Signing the Long-Term Signature Agreement assures that relevant information can be sent to your insurance company if insurance claims are filed on your behalf.
3. **Consent for the Treatment of Minors:** To be completed by parents or legal guardians of students who will be under the age of 18 when arriving on Grounds.
4. **Exemptions to Immunizations**: On occasion, a student may elect to opt out of certain vaccine requirements based on their religious beliefs or medical reasons (TB testing is still required).
5. **Certificate of Immunization & Tuberculosis Screening/Testing:** These must be completed by your healthcare provider. All students are required to have the tuberculosis screening completed.

Sincerely,

Christopher Holstege, M.D.
Executive Director
Department of Student Health

UNIVERSITY of VIRGINIA | Department of Student Health

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INSTRUCTIONS FOR COMPLETING IMMUNIZATION INFORMATION

Non-Medical or Non-Nursing Students

Marking: Please print using black ink. Read carefully and fill in all applicable information. **All information regarding Immunization and Tuberculosis screening/testing must be in English.**

Immunizations: To be completed and signed by a Health Care Provider

Required vaccinations/screening for all students:

A. **Tetanus Diphtheria-Pertussis:** Primary series (DTap, DTP, DT or Td) plus booster **within the last 10 years of 9/1/2017 (fall entry) or 1/1/2018 (spring entry)**. Tdap is the preferred one time booster. Tdap may be given regardless of interval since last Td.

B. **Measles, Mumps, Rubella (MMR):** Two doses of MMR or individual vaccines **of each required**, at least 4 weeks apart, given on or after the first birthday. Not required if born before 1957. Titers proving immunity are acceptable; please provide a copy of the report with the date(s) and result(s) of positive titer(s).

C. **Polio:** Completed primary series is required. Please provide the dates of the primary series as well as any boosters received since that date. A titer proving immunity is acceptable; please enter the date of a positive titer and provide a copy of the report showing the date and result of positive titer.

D. **Hepatitis B:** Undergraduates must have documentation of a completed vaccination series. The Twinrix immunization series is an acceptable alternative, as is a titer proving immunity (please provide a copy of the report with the date and result of positive titer). Undergraduate students may choose to sign a waiver for this immunization.

E. **Meningococcal Vaccine:** For students younger than 22 years of age, one dose of vaccine required after age 16 or signed waiver. Conjugate vaccine preferred. Meningitis B vaccines (Trumenba and Bexsero) do not meet this requirement.

F. **Tuberculosis Screening/Testing:** "Tuberculosis Screening" (page 3) is required for **all students**. "Tuberculosis Testing" (page 4) is also required for students who answer "yes" to any question on page 3. **All screening/testing must be completed on or after 3/1/2017 (fall entry) or 7/1/2017 (spring entry).**

Recommended vaccinations for all students:

A. **Varicella (chicken pox)**: Two doses of vaccine, at least 4 weeks apart, are **strongly recommended** for all college students without other evidence of immunity (e.g. born in the U.S. before 1980, a history of disease, or a positive antibody).

B. **Hepatitis A:** Either alone or in combination with Hepatitis B as Twinrix (combination of Hepatitis A & B). Entering this information in the Hepatitis B section and indicating Twinrix is sufficient documentation.

C. **HPV Vaccine:** The three-shot series is recommended for all females ages 11-26 and males ages 11-21. It also approved for males up to age 26 in certain situations, see CDC guidelines.

D. **Neisseria meningitides (Meningitis) serogroup B vaccine:** Recommended for high risk students with a history of persistent complement component deficiencies or patients with anatomic or functional asplenia. May also be given to anyone 16-23 years old to provide short-term protection. This can be either a two- or three-shot series depending upon the vaccine (Trumenba or Bexsero). The same vaccine must be used for all doses; Student Health only stocks Bexsero.

E. **Influenza (Flu) vaccine:** All students are strongly encouraged to receive seasonal influenza (flu) vaccine when it is available beginning in early fall. Student Health will sponsor a flu clinic on Grounds in the fall to provide students with flu vaccine.

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MR Office Use Only:

Date received: _____

Account #: _____

Non-Medical or Non-Nursing Student Form

Name: _____ Birthday: _____/____/_____
Last First Middle Month Day Year

University ID:_____ Telephone:_____ Term Entering: □ Fall □ Spring

Emergency Contact: (Parent/Guardian/Spouse/Next-of-Kin)

Name:_____ Relationship to student: _____
Last First Middle

Address:_____
No. & Street City State Zip/Postal Code Country

Telephone:(_____)_____ Work/Cell:(_____)_____

Long Term Signature Agreement:

_____
(Last) (First) (Middle)

I hereby assign the benefits of my insurance policy to the University of Virginia Student Health Department and University of Virginia Health System, as appropriate. I understand that I am responsible for all charges that are not paid by that policy.

_____
Student/Parent Signature Date

Before submitting to Student Health, please be sure that you are not a Medical or Nursing Student and that:

- A health care provider has completed and signed both the Immunization Record and the Tuberculosis Screening/Testing Forms.
- Titer results are attached (see instructions).
- All documents are on white paper.
- If applicable, waivers have been signed.
- If your child will be a minor on arrival, you have signed the medical consent form.
- Registration for subsequent semesters will be blocked if you do not comply with immunization requirements.

RETURN TO: Department of Student Health
P.O. Box 800760
400 Brandon Avenue, Room 142
Charlottesville, Virginia 22908-0760
Phone: (434) 924-1525; FAX: (434) 982-4262
Website: http://www.virginia.edu/studenthealth/ Email: sth-mr@virginia.edu

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Certificate of Immunization

Department of Student Health
University of Virginia
P.O. Box 800760
Charlottesville, Virginia 22908-0760
Phone: (434) 924-1525; FAX: (434) 982-4262
Email: sth-mr@virginia.edu

MR Office Use Only:

Date received: _____

Account #: _____

Name: _____ DOB: _____ University ID #:_____
Last First Middle

To be completed and signed by a licensed health care provider. Any attached documents in a language other than English **must be translated into English** by the health care provider.

R	= Required	
R	**Tuberculosis Screening** All students regardless of enrollment status are required to complete the tuberculosis screening form on page 3.	
	IMMUNIZATIONS	
	Diphtheria-Pertussis-Tetanus (DPT) has received ___ doses, last dose given ____/___/___	
	Hepatitis A ① ____/____/____ ② ____/____/____	
R	**Hepatitis B** or **Hep A/B (Twinrix)** Not required for graduate students ① ____/___/____ ② ___/____/____ ③ ___/____/____	**OR** titer indicating immunity. **Must attach lab results.**
	Human Papillomavirus ① ____/____/____ ② ____/____/____ ③ ____/____/____	
R	**Measles, Mumps, Rubella (MMR):** Received after first birthday ① ____/____/____ ② ____/____/____ **OR** **Measles (Rubeola)**: ① ____/____/____ ②___/____/____ **Mumps:** ① ____/____/____ ②___/____/____ **Rubella:** ① ____/____/____ ②___/____/____	**OR** titer(s) indicating positive immunity **Must attach lab results.**
R	**Meningococcal vaccine-**students < 22 years of age ① ___/____/____ ② ___/____/____	□ Menactra (recommended) □ Menveo (recommended) □ Menomune
	Meningitis B ① ___/____/____ ② ___/____/____ ③ ___/____/____	□ Bexsero □ Trumenba
	Other Immunizations: _____ (Name) ____/____/____ _____ (Name) ____/____/____ _____ (Name) ____/____/____ _____ (Name) ____/____/____	
R	**Polio:** **OPV alone (oral Sabin 3 doses)** #1___/___/___ #2___/___/___ #3___/___/___ **IPV/OPV sequential** #1___/___/___ #2___/___/___ #3___/___/___ #4___/___/___ **IPV alone (injected Salk four doses)** #1___/___/___ #2___/___/___ #3___/___/___ #4___/___/___	**OR** titer indicating positive immunity **Must attach lab results.**
R	**Tetanus, diphtheria, pertussis (Tdap)** within 10 yrs ____/____/____	**OR Tetanus diphtheria (Td)** within 10 yrs ____/____/____
	Varicella (Chicken Pox) strongly recommended Date of disease: ___/____/____ **OR vaccines** ① ___/____/____ ② ___/____/____ 2 doses, ≥ 1 mo. apart	**OR** titer indicating immunity. **Must attach lab results.**

Consent for the Treatment of Minors
(Students 17 years and younger)

The University of Virginia Student Health Department has my permission to treat my minor child in the event of a medical emergency. The University of Virginia Student Health Department also has my permission to treat my child for routine medical care, including check-ups, immunizations, and/or treatment for minor injuries and illnesses.

_____
Signature of Parent/Legal Guardian Date

Hepatitis B Vaccine Waiver
Review vaccine information before signing:
http://www.immunize.org/vis/hepatitis_b.pdf
I have read and reviewed information on the risk associated with hepatitis B disease, availability and effectiveness of any vaccine against hepatitis B disease and I choose not to be vaccinated against hepatitis B disease.

_____
Signature of Student or Parent/Legal Guardian Date

Meningococcal Vaccine Waiver
Review vaccine information before signing:
http://www.immunize.org/vis/meningococcal_mcv_mpsv.pdf
I have read and reviewed information on the risk associated with meningococcal disease, availability and effectiveness of any vaccine against meningococcal disease and I choose not to be vaccinated against meningococcal disease.

_____
Signature of Student or Parent/Legal Guardian Date

RELIGIOUS EXEMPTION*
I wish to be exempt from the immunization requirements noted on the University of Virginia Pre-Entrance Health Record because administration of immunizing agents conflicts with my religious beliefs. I release the Commonwealth of Virginia, the University of Virginia and their agents and employees from any responsibility for any impairment of my health resulting from this exemption.

_____
Signature of Student or Parent/Legal Guardian Date

***Does not apply to tuberculosis (TB) Screening/Testing**

SIGN HERE

_____
Health Care Provider or Health Department Signature Date

Medical Exemption -- *Does not apply to tuberculosis (TB) Screening/Testing
As specified in the Code of Virginia §23.1-800, I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

DTP/DTaP/Tdap:[ ]; DT/Td:[ ]; OPV/IPV:[ ]; Measles:[ ]; Rubella:[ ]; Mumps:[ ]; Hepatitis B:[ ]; Hepatitis A [ ]; Varicella:[ ]; Meningococcal:[ ] This contraindication is permanent: [ ] or temporary [ ] and expected to preclude immunizations until: Date (Mo., Day, Yr.):_____

_____
Signature of Medical Provider/Health Department Official Date

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TUBERCULOSIS SCREENING

Name: _____ DOB: _____ University ID #:_____
Last First Middle

The Centers for Disease Control and the U.S. Public Health Service recommend that tuberculosis testing be performed on all individuals who may be at increased risk of tuberculosis disease. For more information, visit http://www.acha.org or refer to the CDC's Core Curriculum on Tuberculosis available at http://www.cdc.gov/nchstp/tb/pubs/corecurr/

1. Have you had a prior positive TB test? (If yes, you must complete Page 4). ☐ Yes ☐ No
2. Have you ever been a close contact with persons known or suspected to have active TB disease? ☐ Yes ☐ No
3. Have you been a resident, employee and/or volunteer in a high risk setting such as long-term care facilities, homeless shelters or correctional facilities? ☐ Yes ☐ No
4. Have you been a healthcare worker or volunteer? ☐ Yes ☐ No
5. Have you ever injected illegal drugs? ☐ Yes ☐ No
6. Do you have signs or symptoms of active TB disease: unexplained fever, weight loss, loss of appetite, night sweats, persistent cough for more than 3 weeks, cough with production of bloody sputum? ☐ Yes ☐ No
7. Do you have a clinical condition such as HIV, diabetes, cancer, kidney disease, silicosis, leukemia or lymphoma, chronic malabsorption syndromes, removal of part of your stomach or have been on prolonged corticosteroid or immunosuppressive therapy? ☐ Yes ☐ No
8. Have you had frequent or prolonged visits* to one or more of the countries or territories listed below with a high prevalence of TB disease? If yes, which country? _____ ☐ Yes ☐ No
   The significance of the travel exposure should be discussed with a health care provider and evaluated.
9. Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country below)? ☐ Yes ☐ No

Afghanistan	China, Macao SAR	India	Mozambique	Sierra Leone
Algeria	Colombia	Indonesia	Myanmar	Singapore
Angola	Comoros	Iraq	Namibia	Solomon Islands
Anguilla	Congo	Kazakhstan	Nauru	Somalia South Africa
Argentina	Côte d'Ivoire	Kenya	New Caledonia	South Sudan
Armenia	Democratic People's Republic of Korea	Kiribati	Nepal	Sri Lanka
Azerbaijan	Democratic Republic of the Congo	Kuwait	Nicaragua	Sudan
Bangladesh	Djibouti	Kyrgyzstan	Niger	Suriname
Belarus	Dominican Republic	Lao People's Democratic Republic	Nigeria	Swaziland
Belize	Ecuador	Latvia	Northern Mariana Islands	Syrian Arab Republic
Benin	El Salvador	Lesotho	Pakistan	Tajikistan
Bhutan	Equatorial Guinea	Liberia	Palau	Thailand
Bolivia (Plurinational State of)	Eritrea	Libya	Panama	Timor-Leste
Bosnia and Herzegovina	Ethiopia	Lithuania	Papua New Guinea	Togo
Botswana	Fiji	Madagascar	Paraguay	Tunisia
Brazil	Gabon	Malawi	Peru	Turkmenistan
Brunei Darussalam	Gambia	Malaysia	Philippines	Tuvalu
Bulgaria	Georgia	Maldives	Portugal	Uganda
Burkina Faso	Ghana	Mali	Qatar	Ukraine
Burundi	Greenland	Marshall Islands	Republic of Korea	United Republic of Tanzania
Cabo Verde	Guam	Mauritania	Republic of Moldova	Uruguay
Cambodia	Guatemala	Mauritius	Romania	Uzbekistan
Cameroon	Guinea	Mexico	Russian Federation	Vanuatu
Central African Republic	Guinea-Bissau	Micronesia (Federated States of)	Rwanda	Venezuela (Bolivarian Republic of)
Chad	Guyana	Mongolia	Sao Tome and Principe	Viet Nam
China	Haiti	Montenegro	Senegal	Yemen
China, Hong Kong SAR	Honduras	Morocco	Serbia	Zambia
				Zimbabwe

☐ **Patient has answered "YES" to 1 or more of the above questions; health care provider must complete Page 4.**
☐ **Patient has answered "NO" to ALL of the above questions.** No TB test or completion of page 4 is required.

I have reviewed the above Tuberculosis screening (and completed and signed page 4 if required).

Health Care Provider (printed):_____ Health Care Provider Signature:_____

Date_____ Phone_____

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TUBERCULOSIS TESTING

Name: _____ DOB: _____ University ID #:_____
Last First Middle

Students **MUST** undergo one Interferon Gamma Release Assay Test (IGRA) **OR** one Tuberculin Skin Test (TST). All testing and X-rays must be done during time frames prior to semester start:

Fall start: on or after March 1 | Spring start: on or after July 1

A. IGRA (recommended for students who have received BCG vaccine)

Date performed:_____ Result:_____ □ Positive □ Negative (Attach copy of lab report)
□ Quantiferon Gold or □ T-Spot

IGRA = Quantiferon Gold or T-Spot. Indeterminate or borderline results are not acceptable. Repeat test or administer two-step TST.

B. TST

Date placed:_____ Date read:_____ Result:_____ mm □ Positive □ Negative

A PPD/TST of ≥ 10 mm induration is considered positive.
However ≥ 5 is positive if the patient is immunocompromised, has had recent exposure to someone with active disease, or has changes on x-ray consistent with past TB disease.

C. History of a prior Positive IGRA or TST - TB Symptom Survey required

Date of positive IGRA:_____ Result :_____ mm □ Quantiferon Gold or □ T-Spot **OR** Date of positive TST: _____

TB Symptom Survey (Check all that apply)
□ None □ Cough>3 weeks with or without sputum production □ Coughing up blood □ Unexplained fever
□ Poor appetite □ Unexplained weight loss □ Night sweats □ Fatigue

If yes to any question, please explain further_____
_____

D. Chest X-ray: Date:_____ □ Positive □ Negative
Required **ONLY** if POSITIVE IGRA or POSITIVE TST. Chest x-ray required within six months of semester start date – **Fall: on or after March 1 | Spring: on or after July 1** – unless patient has a known prior positive TB test and is able to provide official documentation of all of the following: 1) negative chest x-ray at or after diagnosis, 2) completion of treatment for latent TB infection, and 3) negative symptom screen (above).
Attach a copy of the written x-ray report in English.

E. Treatment for TB disease or Latent TB Infection □ Completed □ Ongoing

Dates of treatment regimen: _____ to _____ (attach documentation)
Date of chest x-ray obtained prior to treatment: _____ □ Positive □ Negative

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Health Care Provider (printed):_____ Health Care Provider Signature:_____

Date_____ Phone_____