

Dear new University of Virginia student:

The Department of Student Health and Wellness congratulates you on your acceptance to UVA! Our faculty and staff are here to help you maintain your well-being and to restore your health in the event of illness, injury, or a mental health concern. **Please note that remote services are available to you during periods of distance learning, such as during the novel coronavirus pandemic.**

Building immunity to common communicable diseases is a critical first step in protecting your personal health. Completion of the **pre-entrance health form** (included in the following pages) allows you to demonstrate that you have met the basic immunization requirements known to promote healthy communities. Another important step in preparing for school is to plan for your unique health care needs.

Sincerely,
Chris Holstege, M.D.
Executive Director, UVA Department of Student Health & Wellness



RESOURCES:

- **Scheduling Visits:** After you complete and submit your pre-entrance health form, call **434-924-5362** if you'd like to schedule an appointment in our department. To learn more about the services and resources we offer, visit studenthealth.virginia.edu
- **Connect with Local Specialists:**
Care Managers can offer advice to new students who are seeking medical and mental health specialists. Care Managers can be reached in Medical Services by calling **434-982-3915** or in Counseling & Psychological Services (CAPS) by calling **434-243-5150**.
- **Allergy Clinic:** Our allergy clinic can continue allergy immunotherapy injections ordered by your current allergist while you are at UVA. To learn more, visit: studenthealth.virginia.edu/allergy-clinic
- **Student Disability Access Center (SDAC):**
SDAC provides a wide range of individualized services and accommodations to ensure an inclusive and accessible educational experience for all students. Learn more: studenthealth.virginia.edu/sdac

IMPORTANT DUE DATES:

- **Pre-Entrance Health Form**
Fall Entry: **August 1, 2020**
Spring Entry: **January 31, 2021**
You and your health care provider must complete and sign the pre-entrance health form. Submit your form by uploading a digital version to our secure website:
healthyhoos.virginia.edu
(requires NetBadge account)
Click on "Upload" and follow the instructions. Questions? Contact Medical Records:
434-924-1525
- **Health Insurance:**
UVA requires all students to have health insurance. You must either submit proof of insurance or enroll in the UVA-sponsored Aetna student health plan.
Fall Entry: Enroll or submit proof from:
July 20, 2020 - August 31, 2020
Spring Entry: Enroll or submit proof from:
November 16, 2020 - February 1, 2021
To learn more, start the enrollment process, or submit proof of insurance:
studenthealth.virginia.edu/insurance
Additional questions? Call **434-243-2702** or email **sth-ins@virginia.edu**

Entire Form due August 1st, 2020 for Fall or January 31st, 2021 for Spring to avoid \$100 processing fee.

Pre-Entrance Health Form: PART I

[TO BE COMPLETED BY INCOMING STUDENT OR PARENT/LEGAL GUARDIAN]

Student Name: _____
Last First Middle

Date of Birth: ____/____/____ University ID# _____ State or Country of Birth: _____

Address: _____
Street City State Zip

Name or parent or Legal Guardian 1: _____ Phone ____ - ____ - ____ Work or Cell ____ - ____ - ____

Name of Parent or Legal Guardian 2: _____ Phone ____ - ____ - ____ Work or Cell ____ - ____ - ____

Emergency Contact: _____ Phone ____ - ____ - ____ Work or Cell ____ - ____ - ____

Long Term Signature Agreement

To be completed by the student or parent/legal guardian for minor. Signing this Long-Term Signature Agreement assures that relevant information can be sent to your insurance company if insurance claims are filed on your behalf.

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: ____/____/____

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

To be completed by parents or legal guardians of students who will be under the age of 18 when arriving on Grounds.

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

Student/Parent Signature: _____ Date: ____/____/____

Alert: Health Insurance Verification Program

The University of Virginia requires all students who pay the comprehensive fee with their tuition to have health insurance that meets specific coverage requirements (i.e., comparable coverage). Proof of insurance for the Health Insurance Verification program must be submitted online between July 20, 2020 and August 31, 2020 in order to meet this requirement at the following address:
www.uvastudentinsurance.com

If proof of comparable coverage is not submitted (whether a student fails to submit any documentation or because a student's health plan is determined not to provide adequate comparable coverage), the student will be responsible for the full cost for single coverage under the University-endorsed Aetna Student Health Insurance plan.

For more information: <https://www.studenthealth.virginia.edu/health-insurance-verification>

Entire Form due August 1st, 2020 for Fall or January 31st, 2021 for Spring to avoid \$100 processing fee.

Pre-Entrance Health Form: PART II

[TO BE COMPLETED BY INCOMING STUDENT OR PARENT/LEGAL GUARDIAN]

Tuberculosis (TB) Screening Questionnaire: Students have the option of completing Part II online.*

Have you ever had close contact to someone with infectious TB disease at any time? ☐ YES ☐ NO

Have you had a previous positive TB test? ☐ YES ☐ NO

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ☐ YES ☐ NO

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? ☐ YES ☐ NO

Do you have a suppressed immune system (ex. HIV infection, injection drug use, organ transplant recipient, treatment with immunosuppressant medication)? ☐ YES ☐ NO

Do you have a medical condition with increased risk for progression to TB disease (ex. body weight < 10% ideal, silicosis, diabetes, chronic renal failure, gastrectomy, jejunoileal bypass, solid organ transplant, head/neck cancer)? ☐ YES ☐ NO

Were you born or had travel/ residence for > 3months 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	Colombia	India	Myanmar (Burma)	Solomon Islands
Algeria	Comoros	Indonesia	Namibia	Somalia
Angola	Congo	Iraq	Nauru	South Africa
Anguilla	Côte d'Ivoire	Kazakhstan	Nepal	South Korea (Republic of Korea)
Argentina	Democratic Republic of the Congo	Kenya	Nicaragua	South Sudan
Armenia	Djibouti	Kiribati	Niger	Sri Lanka
Azerbaijan	Dominican Republic	Kuwait	Nigeria	Sudan
Bangladesh	Ecuador	Kyrgyzstan	Niue	Suriname
Belarus	El Salvador	Lao People's Democratic Republic	Northern Mariana Islands	Tanzania (United Republic)
Belize	Equatorial Guinea	Latvia	North Korea (Democratic People's Republic)	Tajikistan
Benin	Eritrea	Lesotho	Pakistan	Thailand
Bhutan	Eswatini (formerly Swaziland)	Liberia	Palau	Timor-Leste
Bolivia	Ethiopia	Libya	Panama	Tokelau
Bosnia and Herzegovina	Fiji	Lithuania	Papua New Guinea	Togo
Botswana	French Polynesia	Madagascar	Paraguay	Trinidad
Brazil	Gabon	Malawi	Peru	Tunisia
Brunei Darussalam	Gambia	Malaysia	Philippines	Turkmenistan
Bulgaria	Georgia	Maldives	Portugal	Tuvalu
Burkina Faso	Ghana	Mali	Qatar	Uganda
Burundi	Greenland	Marshall Islands	Romania	Ukraine
Cabo Verde	Guam	Mauritania	Russian Federation	Uruguay
Cambodia	Guatemala	Mexico	Rwanda	Uzbekistan
Cameroon	Guinea	Micronesia (Federated States of)	Sao Tome and Principe	Vanuatu
Central African Republic	Guinea-Bissau	Moldova (Republic of)	Senegal	Venezuela
Chad	Guyana	Mongolia	Serbia	Viet Nam
China	Haiti	Morocco	Sierra Leone	Yemen
China, Hong Kong SAR	Honduras	Mozambique	Singapore	Zambia
China, Macao SAR				Zimbabwe

I affirm that all of the above information is accurate.

Student Name: _____ Signature: _____ Date: _____

*To complete online: <https://www.healthyhoos.virginia.edu>. Click on "forms" and select HealthyHoos TB Screening Questionnaire.

Entire Form due August 1st, 2020 for Fall or January 31st, 2021 for Spring to avoid \$100 processing fee.

Pre-Entrance Health Form: PART III

[TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER.]

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form. For more information about immunization requirements or exemption forms:

<http://www.studenthealth.virginia.edu/pre-entrance-health-form>

Required Vaccines	Record Complete Dates (mm/dd/yyyy) of Vaccine Doses Given			
Tdap (one dose required on or after 10 th birthday)	1			
Tetanus Booster (if Tdap > 10 years ago)	1			
Polio (IPV, OPV)	1	2	3	4
Measles, Mumps, Rubella (MMR) Vaccine	1	2		
Measles (Rubeola)	1	2	Or date of Serologic Confirmation of Measles Immunity (must attach copy of lab result):	
Rubella	1		Or date of Serologic Confirmation of Rubella Immunity (must attach copy of lab result):	
Mumps	1	2	Or date of Serologic Confirmation of Mumps Immunity (must attach copy of lab result):	
Meningococcal Vaccine (A, C, Y, W-135) (initial or booster dose must be on or after 16 th birthday) Required only for students < 22 years of age.	1			
Hepatitis B Vaccine <input type="checkbox"/> 2-dose vaccine used to complete series.	1	2	3	Or date of Serologic Confirmation of Hepatitis B Immunity (must attach copy of lab result):
Recommended Vaccines	Record Complete Dates (mm/dd/yyyy) of Vaccine Doses Given			
Hepatitis A	1	2		
Human Papillomavirus Vaccine (HPV)	1	2	3	
Serogroup B Meningococcal Vaccine <input type="checkbox"/> MenB-4C <input type="checkbox"/> MenB-FHpb	1	2	3	
Varicella	1	2	Or date of Varicella Disease or Serologic Confirmation of Varicella Immunity (must attach copy of lab result):	
Other	1	2	3	4
Other	1	2	3	4
Required Tuberculosis Screening (all students): All steps must be after 3/1/20 (Fall) or 7/1/20 (Spring)				
Tuberculosis Screening Questionnaire Result (see page 2)	<input type="checkbox"/> Positive (any questionnaire response of "yes")	<input type="checkbox"/> Negative (all questionnaire responses "no")		
Tuberculosis Testing Result. Required only if TB Screening Questionnaire Positive. IGRA required for students from any country listed on page 2. IGRA preferred for all other students.	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Test method: <input type="checkbox"/> IGRA <input type="checkbox"/> PPD	Date of Test:	Must attach copy of result for IGRA.
Chest X-ray result. Required only if Tuberculosis Testing Positive.	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	Date of test:	Must attach copy of report.
All students with a positive IGRA or TST and no signs of active disease on chest x-ray should receive education and treatment recommendations for Latent Tuberculosis Infection (LTBI). LTBI must be reported in VA: http://www.vdh.virginia.gov/tuberculosis/				

HEALTH CARE PROVIDER:

Signature of Medical Provider/Health Department Official: _____

Medical Provider Printed Name: _____ Date: _____

Address: _____ Phone: ____ - ____ - ____