

Dear New University of Virginia student:

Congratulations on your acceptance to the University. Those of us at the Department of Student Health wish you the best of luck in the pursuit of your scholarly activities.

Prior to your enrollment we need information about your health status. Some information is needed to meet requirements of Virginia law (immunizations), to meet University requirements (health insurance), and to assist us in caring for you if you need health services. **The Pre-entrance Health Record is pages 2-5 of this document (below) or you may call 434-924-1525 to receive a form by mail.** It is important that you complete the Pre-entrance Health Record accurately and **return it by August 31, 2008.** If your form is not postmarked by August 31, you will be subject to a late fee of \$100. Student Health offers a secure Web site (<https://www.healthyhoos.virginia.edu>) where you may enter immunization data to help you assure you have completed all the vaccine requirements prior to submitting the hard copy. Before returning the Pre-entrance Health Record, please make certain the following items are complete:

#### **University of Virginia Pre-entrance Health Record**

- ◇ All personal information, including parent/guardian/next-of-kin/spouse information.

#### **Health Insurance Information**

- ◇ Health insurance information and copy of insurance card(s), including prescription plans, is a requirement.
- ◇ **Registration for subsequent semesters will be blocked if not provided.**

#### **Long-Term Signature Agreement**

- ◇ If insurance claims are filed on your behalf, signature of the Long-Term Agreement assures that relevant information can be sent to your insurance company.

#### **Immunization Record Parts A. and B. (Based on national guidelines and Virginia law.)**

Registration for subsequent semesters will be blocked if you do not comply with immunization requirements. Section I must be completed by all students. Section II should be carefully reviewed for any additional recommended vaccines. Section IV is for medical and nursing students only.

- ◇ Either two (2) doses of MMR (or two doses of each individual measles, mumps, or rubella vaccine) or a positive blood test for each disease are required. **All medical and nursing students must comply with this requirement.**
- ◇ Meningococcal meningitis vaccine is required by Virginia law for all new undergraduates unless a waiver is signed. The waiver and frequently asked questions are available at <http://etg07.etc.virginia.edu/uvaformsfiles/std-hlth/hepbmenin-waiver.pdf>.
- ◇ Hepatitis B vaccine is required by Virginia law for all new undergraduates unless a waiver is signed. The waiver and frequently asked questions are available at <http://etg07.etc.virginia.edu/uvaformsfiles/std-hlth/hepbmenin-waiver.pdf>.
- ◇ Please consider the recommended vaccinations for HPV, varicella (chicken pox), hepatitis A, and pertussis or whooping cough (Tdap). All vaccines are generally available for a fee to students at Student Health or during special vaccine clinics during summer Orientation and the fall semester, but we encourage students to be immunized prior to enrollment.
- ◇ Medical and nursing students have additional special requirements -- see Section IV.
- ◇ **Signature** of licensed health care provider or certification from health agency or clinic at the end of **BOTH** the Immunization Record and Tuberculosis Screening form (see below) is required.

#### **Tuberculosis Screening**

- ◇ Results of tuberculosis screening should be completed by a clinician or health department in the appropriate section of the health form. New national guidelines have changed the screening process -- information is available on the Tuberculosis Screening form.
- ◇ Medical and nursing students may not use this form -- see Section IV.
- ◇ **Signature** of licensed health care provider or certification from health agency or clinic at the end of the Tuberculosis Screening form is required.

#### **Medical Consent for Minors**

- ◇ If you will be under the age of 18 when at U.Va., a parent or legal guardian must sign a consent to permit treatment at Student Health and the U.Va. Hospital.

#### **Medical or Religious Exemptions to Immunization**

- ◇ If applicable, sign the appropriate "Exemption" section (TB screening is still required).
- ◇ Exemption from immunization may result in quarantine of unimmunized students off Grounds in the event of a contagious disease outbreak.

We do not require information about past medical problems. If you feel additional information about your health history would help us in caring for you, please send information on a separate sheet attached to the health record. We hope your move to the University goes smoothly, and we look forward to serving you in the future.

Sincerely,

Dr. James C. Turner  
Executive Director, Student Health



UNIVERSITY OF VIRGINIA  
 PRE-ENTRANCE HEALTH RECORD  
 Department of Student Health  
 P.O. Box 800760

Charlottesville, Virginia 22908-0760  
 Phone: (434) 924-1525; FAX: (434) 982-4262  
 Website: <http://www.virginia.edu/studenthealth/>

**FORM MUST BE POSTMARKED BY  
 AUGUST 31, 2008 FOR FALL ENTRANCE OR  
 JANUARY 31, 2009 FOR SPRING ENTRANCE  
 TO AVOID A \$100 PROCESSING FEE.**

TO THE STUDENT: Please type or print in black ink, answering all questions. This information will become part of your confidential medical record. Please attach a separate sheet if you need extra space to answer any questions.

Name \_\_\_\_\_ Social Security Number: \_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_  
 Last First Middle

Address \_\_\_\_\_  
 No. & Street City State Zip

Telephone (\_\_\_\_) \_\_\_\_\_ Sex: M  F  Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MM DD YYYY

UVa School you are entering: \_\_\_\_\_

Check one: Undergraduate  Graduate  Term entering: Fall  Spring  20\_\_\_\_

If you have previously enrolled in UVa, please give dates: from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MM YYYY MM YYYY \*

**\*If you are returning to UVa after more than 2 years, or moving from an undergraduate to a graduate program, a new Pre-Entrance Health Record must be completed.**

**PARENT/GUARDIAN/NEXT-OF-KIN/SPOUSE INFORMATION (for contact in case of emergency)**

Name \_\_\_\_\_ Relationship to student: \_\_\_\_\_  
 Last First Middle

Address \_\_\_\_\_  
 No. & Street City State Zip

Telephone (\_\_\_\_) \_\_\_\_\_

PRIMARY CARE PHYSICIAN NAME AND PHONE NUMBER: \_\_\_\_\_

**HEALTH INSURANCE IS A REQUIREMENT FOR ALL UNIVERSITY OF VIRGINIA STUDENTS.  
 (Registration for subsequent semesters will be blocked if information not provided)**

**ATTACH A COPY OF YOUR INSURANCE CARD, FRONT AND BACK, AND YOUR PRESCRIPTION CARD, IF SEPARATE, TO THIS FORM. Whenever visiting Student Health or other care provider, have your insurance card(s) with you.**

If you will purchase the CHICKERING HEALTH INSURANCE PLAN endorsed by the University of Virginia, indicate by checking the box below. Chickering's phone number is 800-466-3027 or visit the web site, [www.chickering.com](http://www.chickering.com).

I WILL PURCHASE THE CHICKERING STUDENT HEALTH PLAN  Yes

**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. I authorize Student Health to release to my insurance company information needed in order to obtain pre-authorization for treatment or process a claim for services rendered.

I understand that this assignment and authorization will remain in effect indefinitely or until such time that I give written notice to the contrary.

\_\_\_\_\_  
 Date Student Signature

**OFFICE USE ONLY:** Date Received: \_\_\_\_\_ Account Number: \_\_\_\_\_

Scanned by/Date: \_\_\_\_\_ Attached by/Date: \_\_\_\_\_ Reviewed by/Date: \_\_\_\_\_

**IMMUNIZATION RECORD**

Name \_\_\_\_\_  
 Last First Middle  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 MM DD YYYY

FORM MUST BE POSTMARKED BY  
 AUGUST 31, 2008 FOR FALL ENTRANCE OR  
 JANUARY 31, 2009 FOR SPRING ENTRANCE  
 TO AVOID A \$100 PROCESSING FEE.

**Part A: Parts A & B TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.** Enter all information in English.  
**Registration for next semester will be blocked if all required immunizations are not up to date.**

I. REQUIRED IMMUNIZATIONS	DATE ADMINISTERED (MM/DD/YY)
<b>Tetanus-Diphtheria-Pertussis:</b> Primary series (DTap, DTP, DT or Td) Booster (Tdap or Td) within 10 years of 9/1/2008 Medical and Nursing students, see additional requirements section below.	Primary Series: (1) ____/____/____ (2) ____/____/____ (3) ____/____/____ (4) ____/____/____ Tdap Booster: ____/____/____ (recommended) at least 5 years after last dose of Td (may be given simultaneously with Menactra) Td Booster: ____/____/____
<b>Measles, Mumps, Rubella (MMR):</b> 2 doses required at least 1 month apart <b>OR ALL 3 OF THESE CRITERIA ARE MET:</b> Measles (Rubeola) Mumps Rubella (German Measles) Not required if born before 1957 EXCEPT for medical and nursing students	(1) ____/____/____ (2) ____/____/____ OR titer indicating positive immunity ____/____/____ (1) ____/____/____ (2) ____/____/____ OR titer indicating positive immunity ____/____/____ (1) ____/____/____ (2) ____/____/____ OR titer indicating positive immunity ____/____/____
<b>Polio</b>	Series completed ____/____/____ OR titer indicating positive immunity ____/____/____ Last Booster ____/____/____
<b>Hepatitis B:</b> Must receive all three doses; required for undergraduates, medical and nursing students only <b>Waiver not available for medical and nursing students.</b> See additional requirements section below.	(1) ____/____/____ (2) ____/____/____ (3) ____/____/____ OR titer indicating positive immunity ____/____/____ <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis B OR <input type="checkbox"/> waiver (not medical/nursing students) <input type="checkbox"/> Twinrix <input type="checkbox"/> Twinrix <input type="checkbox"/> Twinrix OR <input type="checkbox"/> not an undergraduate Waiver available at <a href="http://uvaforms.virginia.edu/uvaforms/files/std-hlth/hepbmenin-waiver.pdf">http://uvaforms.virginia.edu/uvaforms/files/std-hlth/hepbmenin-waiver.pdf</a>
<b>Meningococcal Meningitis:</b> Required for undergraduates only. One dose of conjugate vaccine preferred. Polysaccharide acceptable alternative if given on or after 9/1/2006.	____/____/____ OR <input type="checkbox"/> waiver <input type="checkbox"/> Menactra (conjugate) OR <input type="checkbox"/> not an undergraduate <input type="checkbox"/> Menomune (polysaccharide) Waiver available at <a href="http://uvaforms.virginia.edu/uvaforms/files/std-hlth/hepbmenin-waiver.pdf">http://uvaforms.virginia.edu/uvaforms/files/std-hlth/hepbmenin-waiver.pdf</a>

II. RECOMMENDED VACCINATIONS	DATE ADMINISTERED (MM/DD/YY)
<b>Varicella (chicken pox):</b> Two doses 1 month apart for adults under age 30 with no disease history.	(1) ____/____/____ (2) ____/____/____
<b>Hepatitis A</b> (If Twinrix, see Required Immunizations above)	(1) ____/____/____ (2) ____/____/____ <input type="checkbox"/> Twinrix noted above
<b>HPV Vaccine (Gardasil):</b> Recommended for all females 26 years of age or younger	1) ____/____/____ (2) ____/____/____ (3) ____/____/____

III. OTHER VACCINATIONS RECEIVED	DATE ADMINISTERED (MM/DD/YY)
<b>Other (specify):</b> _____	(1) ____/____/____ (2) ____/____/____

IV. ADDITIONAL REQUIREMENTS FOR MEDICAL AND NURSING STUDENTS	DATE ADMINISTERED (MM/DD/YY)
<b>Rubella antibody titer:</b> The titer must prove immunity.	____/____/____ Results: <input type="checkbox"/> Immune <input type="checkbox"/> Non-immune
<b>Hepatitis B:</b> Must receive all three doses of vaccine OR have positive antibody test	(1) ____/____/____ (2) ____/____/____ (3) ____/____/____ OR titer indicating positive immunity ____/____/____ <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis B Titer Result: <input type="checkbox"/> Immune <input type="checkbox"/> Non-immune <input type="checkbox"/> Twinrix <input type="checkbox"/> Twinrix <input type="checkbox"/> Twinrix
<b>Varicella (chicken pox):</b> Do you have a physician report of varicella disease or dates of varicella vaccine? If no, a varicella antibody blood titer test that proves immunity is required.	If yes, date of disease: ____/____/____ If no, titer indicating positive immunity ____/____/____ OR vaccination dates: (1) ____/____/____ Titer Result: <input type="checkbox"/> Immune <input type="checkbox"/> Non-immune (2) ____/____/____
<b>Tuberculosis:</b> All medical and nursing students are required to have a 2-step PPD or a QuantiFERON-TB (QFT) test. Period between the 2 PPDs must be 1 week to 3 months or series must be repeated. Screening form not applicable. Process to be completed on or after 3/1/2008.	PPD 1: Date placed: ____/____/____ Date read: ____/____/____ Result: _____ mm PPD 2: Date placed: ____/____/____ Date read: ____/____/____ Result: _____ mm Record actual mm of induration, transverse diameter; if no induration, write "0" PPD Interpretation (based on mm of induration and factors at 2nd PPD: <input type="checkbox"/> Positive <input type="checkbox"/> Negative QFT: Date: ____/____/____ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
<b>Chest X-Ray:</b> required if PPD or QFT is positive; must have been performed on or after March 1, 2008.	Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Date of chest x-ray: ____/____/____ <input type="checkbox"/> INH Initiated Date: ____/____/____ X ____ months
<b>Tdap Booster:</b> Tdap should be administered prior to enrollment in nursing or medical school. If last Td given within last 2 years, Tdap can be postponed until appropriate date after enrollment (with documentation). Booster (Tdap or Td) within 10 years of 9/1/2008.	Primary Series: (1) ____/____/____ (2) ____/____/____ (3) ____/____/____ (4) ____/____/____ Tdap Booster: ____/____/____ (recommended) at least 2 years after last dose of Td (may be given simultaneously with Menactra) Td Booster: ____/____/____

**HEALTH CARE PROVIDER: Signature required as validation of correct immunization information.**

\_\_\_\_\_ (Name) \_\_\_\_\_ (Signature) \_\_\_\_\_ (Date)

**Continue on to Part B for Tuberculosis Screening (Required for all students EXCEPT Medical and Nursing students - see above)**  
**This requires a visit to your physician.**

**PART B: Tuberculosis Screening: Required of all students EXCEPT Medical and Nursing Students who must receive a 2-step PPD or a QFT test (see Part A above)**

FORM MUST BE POSTMARKED BY AUGUST 31, 2008 FOR FALL ENTRANCE OR JANUARY 31, 2009 FOR SPRING ENTRANCE TO AVOID A \$100 PROCESSING FEE.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_ -- \_\_\_\_ -- \_\_\_\_  
MM DD YYYY

**TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER**

Based on the guidelines published by The American College Health Association, the recommendations from the Centers for Disease Control (CDC) and the American Thoracic Society, Tuberculosis Screening is required **after March 1, 2008** primarily by conducting a **Risk Assessment**. For more information, visit [www.acha.org](http://www.acha.org) or refer to the CDC's Core Curriculum on Tuberculosis available at state health departments or at the following website: [www.cdc.gov/nchstp/tb/pubs/corecurr/](http://www.cdc.gov/nchstp/tb/pubs/corecurr/). Please answer the following questions. If the student is at low risk, a PPD is not required for entrance into college.

1. Does the student have **signs or symptoms of active TB disease**?  YES  NO  
If **NO**, proceed to question 2.

If **YES**, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, QuantiFERON-TB testing, chest x-ray and sputum evaluation as indicated.

2. Is the student a member of a **high risk group** or is the student entering the **Health Profession (medical or nursing student)**?  YES  NO

Categories of high-risk students include those: with HIV infection; who inject drugs; who have resided in, volunteered in or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunioileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone  $\geq$  15 mg/d for  $\geq$  1 month) or other immunosuppressive disorders. **For medical and nursing students, use Immunization Record, Part A, Section IV only.**

If **NO**, continue to question 3.

If **YES**, do one of the following:

--place series of 2 tuberculin skin tests (Mantoux only: Inject 0.1 ml of purified Protein derivative [PPD] tuberculin containing 5 tuberculin units [TU] intradermally into the volar [inner] surface of the forearm.) Record results below or on Immunization Record, Part A, Section IV.

--perform **QuantiFERON-TB test**. Record results below or on Immunization Record, Part A, Section IV. BCG vaccination should not preclude testing of a member of a high-risk Group. If neither test is done, a chest x-ray is required (see **B**. to record x-ray result)

3. Has the student **lived or travelled** (spent 6 weeks or more) in countries where TB is endemic?  YES  NO  
Includes those students who have arrived within the past 5 years from countries other than those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia (USA), Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand.

**\*\* IF NO to #1, #2, & #3, PPD, QFT and Chest X-Ray are not required. No further evaluation is required, PLEASE SIGN BELOW.**

IF YES to any, student must undergo **tuberculin skin test, Quanti-FERON TB or Chest X-ray**. (See #2 above)

**PLEASE USE THE SPACE BELOW TO DOCUMENT TESTING AND/OR CHEST RADIOGRAPHY\***

\* (Based on assessment criteria outlined above) **Not applicable to Medical or Nursing Students; see Part A**

**A. Tuberculin Skin Test (must have been placed on or after March 1, 2008):**

Date given: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date read: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_ mm  
MM DD YY MM DD YY (Record actual mm of induration, transverse diameter; if no induration, write "0")

Interpretation (based on mm of induration as well as risk factors)  Positive  Negative

**B. QuantiFERON-TB Test (must have been performed on or after March 1, 2008):**

Date performed: \_\_\_\_/\_\_\_\_/\_\_\_\_ Results:  Positive  Negative  
MM DD YY

**C. Chest X-Ray (required if PPD or QFT test is positive or if PPD/QFT has not been placed but patient is at risk of disease; must have been performed on or after March 1, 2008):** Result:  Normal  Abnormal Date of chest x-ray: \_\_\_\_/\_\_\_\_/\_\_\_\_

INH Initiated  Date \_\_\_\_\_ X \_\_\_\_\_ months  
MM DD YY

**HEALTH CARE PROVIDER:** (signature required as validation of correct information for TB assessment only)

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

(TB screening must be performed on or after March 1, 2008)

# MEDICAL CONSENT FORM FOR MINORS

FORM MUST BE POSTMARKED BY  
AUGUST 31, 2008 FOR FALL ENTRANCE OR  
JANUARY 31, 2009 FOR SPRING ENTRANCE  
TO AVOID A \$100 PROCESSING FEE.

Dear Parent or Legal Guardian:

The purpose of this consent form is to obtain permission from the parent or legal guardian for the University of Virginia Health System and/or the University of Virginia Student Health Department to treat a patient who is under the age of 18 and therefore legally a minor.

The University of Virginia Health system and/or the University of Virginia Student Health Department have my permission to treat my minor child (name of child) \_\_\_\_\_ in the event of a medical emergency. The UVa Hospital Health System and the Student Health Department also have my permission to treat my child for minor injuries and minor illness (including administration of vaccinations such as tetanus, influenza, and/or meningitis).

_____	_____
Name of Parent or Legal Guardian (print)	Relationship
_____	_____
Signature	Date
_____	(_____) _____
Street Address	Home Phone
_____	(_____) _____
City, State, Zip	Work Phone

## EXEMPTIONS TO PRE-ENTRANCE HEALTH IMMUNIZATIONS REQUIREMENTS (Sec. 23-7.5 Code of Virginia)

### MEDICAL EXEMPTION (PHYSICIAN'S SIGNATURE REQUIRED):

(Print Name of Student) \_\_\_\_\_ should be exempt from some or all of the pre-entrance immunization requirements noted on the University of Virginia Pre-Entrance Health Record. Administration of the following immunizing agents would be detrimental to this student's health:

\_\_\_\_\_

\_\_\_\_\_

(List Immunizations)

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

### RELIGIOUS EXEMPTION\*

I, (print name) \_\_\_\_\_ 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.

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*Does not apply to tuberculosis (TB) testing**