



Fall 2009 and Spring 2010

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 2-7 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, 2009 (January 31, 2010 for spring semester)**. If your form is not postmarked by August 31 (January 31 for spring semester), 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 each of individual measles, mumps, or rubella vaccines) 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://www.virginia.edu/studenthealth/HepBMeninWaive_0910_UID.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://www.virginia.edu/studenthealth/HepBMeninWaive_0910_UID.pdf
- ◇ Please consider the recommended vaccinations for HPV, varicella (chicken pox), hepatitis A, pneumococcus, and pertussis or whooping cough (Tdap). All vaccines are generally available for a fee to students at Student Health or at special vaccine clinics during 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 must undergo tuberculosis testing--See Part B.
- ◇ **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,

James C. Turner, M.D.

Executive Director, Department of Student Health

INSTRUCTIONS FOR COMPLETING THE PRE-ENTRANCE HEALTH FORM

Marking: Please print using black ink. Read carefully and fill in all applicable information. The first and last pages are to be completed by the student/parent and the **second and third pages completed and signed by a licensed health care provider.**

Personal Information: To be completed by the student

Complete all requested demographic information including the name of someone who could be contacted in case of an emergency. Be sure to attach a copy of your insurance and prescription cards or indicate that you intend to purchase the insurance plan endorsed by the University of Virginia. If you don't know your University ID number, it may be available at <http://www.virginia.edu/orientation/ids.html>. If it is not yet available, leave this blank. Signing the Long-Term Signature Agreement assures that, if insurance claims are filed on your behalf, relevant information can be sent to your insurance company.

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

- A. **Tetanus Diphtheria-Pertussis:** Primary series (DTap, DTP, DT or Td) plus booster of Tdap (**available since 6/1/05**) or Td required within 10 years of **9/1/2009**. **Medical and nursing students, see special requirements section below.**
- B. **Measles, Mumps, Rubella (MMR):** Two doses of MMR or individual vaccines required, at least one month apart. Not required if born before 1957 **EXCEPT medical and nursing students**. A titer proving immunity is acceptable; please provide the date and results.
- C. **Polio:** Completed primary series is required. Please provide the date the series was completed as well as any boosters received since that date. A titer proving immunity is acceptable; please provide the date and results.
- D. **Hepatitis B:** Undergraduates and medical and nursing students must have received and documented all three doses. The Twinrix immunization series is an acceptable alternative, as is a titer proving immunity (please provide the date and results). Undergraduate students only may choose to sign a waiver for this immunization series (available at <http://www.virginia.edu/studenthealth/HepBMeninWaive 0910 UID.pdf>); **medical and nursing students are required to meet this requirement and may not sign a waiver.**
- E. **Meningococcal Vaccine:** One dose or a signed waiver must be completed for undergraduate students only. One dose of Menactra (conjugate; **available since 1/14/05**) vaccine preferred. Menomune (polysaccharide) acceptable alternative if given on or after **9/1/2007**. Please indicate vaccination, waiver signed, or not an undergraduate. Waiver available at <http://www.virginia.edu/studenthealth/HepBMeninWaive 0910 UID.pdf>
- F. **Tuberculosis Screening:** All students, **except medical and nursing students**, must have a licensed care provider complete the **Part B: Tuberculosis Screening**. If you answered "Yes" to any question on the form, a two-step PPD test, a QuantiFERON-TB test or a chest x-ray must be performed on or after **3/1/2009**. **Medical and nursing students may not have a screening – see special requirements below.**

Recommended Vaccinations:

- G. **Varicella (chicken pox):** Two doses of vaccine are recommended, 1 month apart, for those adults under age 30 with no disease history.
- H. **Hepatitis A:** If you have received the Twinrix (combination of Hepatitis A and Hepatitis B vaccines), entering this information in the Hepatitis B section and indicating Twinrix is sufficient documentation.
- I. **HPV Vaccine (Gardasil):** The three-shot series is recommended for all females 11-26 years of age.
- J. **Pneumococcal polysaccharide (pneumonia):** One shot is recommended for smokers and asthmatics 19-64 years of age.

SPECIAL REQUIREMENTS FOR MEDICAL AND NURSING STUDENTS

- K. **Rubella Antibody Titer:** A rubella titer is required for medical and nursing students and must prove immunity. Please provide the date and results.
- L. **Hepatitis B:** Medical and nursing students must receive all three doses of vaccine (Twinrix series is an acceptable alternative) or have a positive antibody test. Please provide the date and results.
- M. **Varicella (chicken pox):** Medical and nursing students must have a physician report of varicella disease, dates of the varicella vaccine series or a positive varicella antibody blood titer.
- N. **Tuberculosis:** All medical and nursing students are required to complete tuberculosis testing with either a 2-step PPD or a QuantiFERON-TB (QFT) test. The 2 PPDs must be administered at least 1 week apart and no greater than 3 months or the series must be repeated. Part B. includes instructions. Record actual mm of induration, transverse diameter; if no induration, write "0." All elements of this requirement must have occurred on or after **3/1/2009**.
- O. **Chest X-Ray:** A negative chest x-ray is required if the PPD series or QFT is positive. Chest X-ray is not required if patient is undergoing or has completed treatment for LTBI. The x-ray must have been performed on or after **3/1/2009**.
- P. **Tdap Booster:** Tdap (**available since 6/1/05**) should be administered prior to enrollment in nursing or medical school. If the last Td shot received was within the last 2 years, the Tdap can be postponed until the appropriate date after enrollment (with documentation). The last immunization received (Tdap or Td) must have been within 10 years of **9/1/2009**.



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 IS DUE TO STUDENT HEALTH BY AUGUST 31, 2009 FOR FALL ENTRANCE OR JANUARY 31, 2010 FOR SPRING ENTRANCE

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 _____ University ID Number _____
 Last First Middle

Address _____
 No. & Street City State Zip

Telephone (____) _____ Circle Sex: M F Birthday: ____/____/____
 Month Day Year

UVa School you are entering: _____

Check one: Undergraduate Graduate Circle term entering: Fall Spring 20____

If you have previously enrolled in UVa, please give dates: from ____/____ to ____/____
 Mo/Yr Mo/Yr

If you are returning to school after 2 years or more, 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 AETNA HEALTH INSURANCE PLAN endorsed by the University of Virginia, indicate by checking the box below. Aetna's phone number is 800-466-3027 or visit the web site, www.aetnastudenthealth.com/.

I WILL PURCHASE THE AETNA 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 Signature

OFFICE USE ONLY: Date Received: _____ Account Number: _____

Reviewed by/Date: _____

IMMUNIZATION RECORD

FORM IS DUE TO STUDENT
HEALTH BY AUGUST 31, 2009 FOR
FALL ENTRANCE OR JANUARY 31,
2010 FOR SPRING ENTRANCE

Name _____
Last
First
Middle

Date of Birth _____
Mo
Day
Year
University ID Number: _____

Part A: Parts A & B TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. Enter all information in English. See instructions for more information.

Registration for next semester will be blocked if all required immunizations are not up to date.

I. REQUIRED IMMUNIZATIONS	DATE ADMINISTERED (MM/DD/YY)
Tetanus-Diphtheria-Pertussis:	
Primary Series: (1) ____/____/____ (2) ____/____/____ (3) ____/____/____ (4) ____/____/____	
Tdap Booster: ____/____/____ OR Td Booster: ____/____/____	
Measles, Mumps, Rubella (MMR): (1) ____/____/____ (2) ____/____/____ OR titer indicating positive immunity ____/____/____	
OR	
Measles (Rubeola) (1) ____/____/____ (2) ____/____/____ OR titer indicating positive immunity ____/____/____	
Mumps (1) ____/____/____ (2) ____/____/____ OR titer indicating positive immunity ____/____/____	
Rubella (German Measles) (1) ____/____/____ (2) ____/____/____ OR titer indicating positive immunity ____/____/____	
Polio: Series completed: ____/____/____ OR titer indicating positive immunity ____/____/____	
Last Booster: ____/____/____	
Hepatitis B: (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	
Meningococcal Meningitis: ____/____/____ OR <input type="checkbox"/> waiver	
<input type="checkbox"/> Menactra (conjugate) OR <input type="checkbox"/> not an undergraduate	
<input type="checkbox"/> Menomune (polysaccharide)	

II. RECOMMENDED VACCINATIONS	DATE ADMINISTERED (MM/DD/YY)
Varicella (chicken pox): (1) ____/____/____ (2) ____/____/____	
Hepatitis A: (1) ____/____/____ (2) ____/____/____ <input type="checkbox"/> Twinrix noted above	
HPV Vaccine (Gardasil): (1) ____/____/____ (2) ____/____/____ (3) ____/____/____ (Females 11-26 y.o.)	
Pneumococcal polysaccharide: ____/____/____ (Current smokers and asthmatics 19-64 y.o.)	

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

IV. SPECIAL REQUIREMENTS FOR MEDICAL AND NURSING STUDENTS	DATE ADMINISTERED (MM/DD/YY)
Rubella antibody titer: ____/____/____ Titer Result: <input type="checkbox"/> Immune <input type="checkbox"/> Non-immune	
Hepatitis B: (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	
Varicella (chicken pox): If had chicken pox, 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) ____/____/____	
Tdap Booster: 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 9/1/2009.	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: ____/____/____
Tuberculosis Screening and Testing: Proceed to Part B	
Chest X-Ray: Proceed to Part B	

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 Form

Name: _____ Date of Birth: ____/____/____ University ID No: _____

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 within six months of college entry primarily by conducting a **Risk Assessment**. For more information, visit 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/. 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 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 jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone \geq 15 mg/d for \geq 1 month) or other immunosuppressive disorders.

If NO, continue to question 3

If YES, place 2-step tuberculin skin test or draw a QFT and record results on next page. Period between the two PPDs must be 1 week but less than 3 months or the series must be repeated (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.) A history of BCG vaccination should not preclude testing of a member of a high-risk Group. **If patient has a history of a positive PPD or QFT, a chest x-ray is required or must be presently undergoing or have completed LTBI treatment (see next page to record results or information).**

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: Albania, American Samoa, Andorra, Antigua and Barbuda, Australia, Austria, Barbados, Belgium, Bermuda, British Virgin Islands, Canada, Cayman Islands, Chile, Cook Islands, Costa Rica, Cuba, Cyprus, Czech Republic, Denmark, Dominica, Finland, France, Germany, Greece, Grenada, Hungary, Iceland, Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Libyan Arab Jamahiriya, Luxembourg, Malta, Monaco, Montserrat, Netherlands, Netherlands Antilles, New Zealand, Norway, Puerto Rico, Saint Kitts and Nevis, St. Lucia, Samoa, San Marino, Slovakia, Slovenia, Sweden, Switzerland, Trinidad and Tobago, Turks and Caicos Islands, United Arab Emirates, United Kingdom, United States Virgin Islands, United States of America

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

IF YES to #1, #2 or #3, , Students should undergo 2-step tuberculin skin test or, QFT test; if either is positive, a Chest X-ray is required, or must be presently undergoing or have completed LTBI treatment. PLEASE PROCEED TO NEXT PAGE.

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, 2009)

FORM IS DUE TO STUDENT
HEALTH BY AUGUST 31, 2009 FOR
FALL ENTRANCE OR JANUARY 31,
2010 FOR SPRING ENTRANCE

Name: _____ Date of Birth: ____/____/____ University ID No: _____

Tuberculosis Testing Form.

- To be used if answers to questions 1, 2 or 3 on previous page were Yes.
- To be used for all health sciences students (nursing and medical).

PLEASE USE THE SPACE BELOW TO DOCUMENT TUBERCULIN TESTING AND/OR CHEST RADIOGRAPHY OR LTBI TREATMENT*

* (Based on assessment criteria outlined on previous page.)

A. 2 Step Tuberculin Skin Test (both must have been placed on or after March 1, 2009)

Test 1: Date given: ____/____/____ Date read: ____/____/____ Result: _____mm
Mo Day Yr Mo Day Yr (Record actual mm of induration, transverse diameter; if no induration, write "0")
Test 2: Date given: ____/____/____ Date read: ____/____/____ Result: _____mm
Mo Day Yr Mo Day Yr (Record actual mm of induration, transverse diameter; if no induration, write "0")

Tests must be at least 1 week but not more than 3 months apart or the series must be repeated.

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, 2009)

Date performed: ____/____/____ Date read: ____/____/____ Results: Positive Negative

C. Chest X-Ray (required if Tuberculin Skin test or QFT is positive; or if history of positive PPD and/or patient is at risk of active disease. Chest X-ray not required if patient is currently undergoing or has completed LTBI treatment; Chest X-ray must have been performed on or after March 1, 2009):

Result: Normal Abnormal Date of chest x-ray: ____/____/____
 INH Initiated Date _____ X _____ months

D. Previously Treated LTBI

Date and result of last chest x-ray: ____/____/____ Result: Normal Abnormal
Dates (i.e. length) and details (i.e. drugs, dose) of LTBI treatment regimen: ____/____/____ to ____/____/____

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, 2009)

MEDICAL CONSENT FORM FOR MINORS

**FORM IS DUE TO STUDENT
HEALTH BY AUGUST 31, 2009 FOR
FALL ENTRANCE OR JANUARY 31,
2010 FOR SPRING ENTRANCE**

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/Guardian of Minor (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) skin test**