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 144
Charlottesville, VA  22908-0760
Phone:  (434) 924-1525;  FAX:  (434) 982-4282
Website:  http://www.virginia.edu/studenthealth
Email:  sth-mr@virginia.edu

Please ensure you have completed all required sections listed below prior to submission. Students with forms postmarked after August 31, 2016 (January 31, 2017 for the spring semester) will be subject to a $100.00 late fee. Student Health offers a secure website (https://www.healthyhoos.virginia.edu) 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 email.

Please note:

1. **Designated Emergency Contact(s):** May be your 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 (page 5).

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. **Ongoing Medical Conditions:** 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.

6. **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
INSTRUCTIONS FOR COMPLETING IMMUNIZATION INFORMATION

Non-Medical or 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 9/1/2016 (fall entry) or 1/1/2017 (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 date the primary series was completed as well as any boosters received since that date. A titer proving immunity is acceptable; please provide the date of a positive titer; please provide a copy of the report with 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 2) is required for **all students.** “Tuberculosis Testing” (page 3) is also required for students who answer “yes” to any question on page 2. **All screening/testing must be completed on or after 3/1/2016 (fall entry) or 7/1/2016 (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](https://www.cdc.gov/vaccines/hcp/adenovirus/index.html).

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.
Certificate of Immunization

<table>
<thead>
<tr>
<th>Name:</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Birthday:</th>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>University ID:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country of Origin:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Contact: (Parent/Guardian/Spouse/Next-of-Kin)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td>Last</td>
<td>First</td>
<td>Middle</td>
<td>Relationship to student:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td>No. &amp; Street</td>
<td>City</td>
<td>State</td>
<td>Zip/Postal Code</td>
<td>Country</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

## IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Vaccine/Immunization</th>
<th>Requirement</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis Screening</td>
<td>All students regardless of enrollment status are required to complete the screening form on page 2.</td>
<td></td>
</tr>
<tr>
<td>Diphtheria-Pertussis-Tetanus (DPT)</td>
<td>has received ___ doses, last dose given <em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td>Tetanus, diphtheria, pertussis (Tdap)</td>
<td>within 10 yrs <em><strong>/</strong></em>/___ OR Tetanus diphtheria (Td) within 10 yrs <em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td><em><strong>/</strong></em>/___ OR Hep A/B (Twinrix) <em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td>Human Papillomavirus</td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, rubella (MMR):</td>
<td>Received after first birthday <em><strong>/</strong></em>/___ OR Measles (Rubeola): <em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td>Mumps:</td>
<td><em><strong>/</strong></em>/___ Rubella: <em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td>Meningococcal vaccine: students &lt; 22 years of age</td>
<td><em><strong>/</strong></em>/___ OR waiver signed <em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td>Meningitis B</td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td>Other Immunizations:</td>
<td><em><strong>/</strong></em>/___</td>
<td></td>
</tr>
<tr>
<td>Polio IPV or OPV</td>
<td>Date series completed: <em><strong>/</strong></em>/___ OR titer indicating positive immunity Must attach lab results.</td>
<td></td>
</tr>
<tr>
<td>Varicella (Chicken Pox)</td>
<td>Date of disease: OR vaccines <em><strong>/</strong></em>/___ OR titer indicating immunity. Must attach lab results.</td>
<td></td>
</tr>
</tbody>
</table>

## 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: ___/___/___

## Hepatitis B Vaccine Waiver

(Review page 4 prior to signing)

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: ___/___/___

## Meningococcal Vaccine Waiver

(Review page 4 prior to signing)

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: ___/___/___

## 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: ___/___/___

---

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

Medical Exemption -- "Does not apply to tuberculosis (TB) Screening/Testing"

As specified in the Code of Virginia §23-7.3, 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/Td/IPV/Hib; Pneumovax; Measles; Rubella; Mumps; HBV; 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: ___/___/___
TUBERCULOSIS SCREENING

Name: ___________________________ DOB: ______________ University ID #: __________

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 3).
   • 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 and/or employee 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?
   • 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. In the past 5 years, have you lived in or traveled extensively to a country NOT listed below? If yes, which country? ________________
   • Yes □ No □

9. Have you lived in the United States for less than 5 years and were born in a country EXCEPT one of the following? If yes, which country:
   • Yes □ No □

<table>
<thead>
<tr>
<th>Country</th>
<th>Country</th>
<th>Country</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albania</td>
<td>American Samoa</td>
<td>Andorra</td>
<td>Antigua &amp; Barbuda</td>
</tr>
<tr>
<td>Austria</td>
<td>Austria</td>
<td>Bahamas</td>
<td>Bahrain</td>
</tr>
<tr>
<td>Belgium</td>
<td>Bermuda</td>
<td>Bonaire, Saint</td>
<td>Canada</td>
</tr>
<tr>
<td>Chile</td>
<td>Cook Islands</td>
<td>Costa Rica</td>
<td>Croatia</td>
</tr>
<tr>
<td>Curacao</td>
<td>Cyprus</td>
<td>Czech Republic</td>
<td>Denmark</td>
</tr>
<tr>
<td>Egypt</td>
<td>Emirates</td>
<td>Eustatius and Saba</td>
<td>Finland</td>
</tr>
<tr>
<td>Germany</td>
<td>Greece</td>
<td>Grenada</td>
<td>Hungary</td>
</tr>
<tr>
<td>Ireland</td>
<td>Israel</td>
<td>Italy</td>
<td>Jamaica</td>
</tr>
<tr>
<td>Jordan</td>
<td>Lebanon</td>
<td>Luxembourg</td>
<td>Malta</td>
</tr>
<tr>
<td>Montserrat</td>
<td>Netherlands</td>
<td>Netherlands Antilles</td>
<td>New Caledonia</td>
</tr>
<tr>
<td>Niue</td>
<td>Norway</td>
<td>Oman</td>
<td>Puerto Rico</td>
</tr>
<tr>
<td>Saint Kitts &amp; Nevis</td>
<td>Saint Lucia</td>
<td>Samoa</td>
<td>San Marino</td>
</tr>
<tr>
<td>Serbia</td>
<td>Sint Maarten (Dutch part)</td>
<td>Slovakia</td>
<td>Slovenia</td>
</tr>
<tr>
<td>Sweden</td>
<td>Switzerland</td>
<td>Syrian Arab</td>
<td>The Former Yugoslav Republic of Macedonia</td>
</tr>
<tr>
<td>Tonga</td>
<td>Turkey</td>
<td>Turks &amp; Caicos</td>
<td>United Arab</td>
</tr>
<tr>
<td>United States</td>
<td>Virgin Islands (US &amp; BR)</td>
<td>Wallis &amp; Futuna Islands</td>
<td>West Bank and Gaza Strip</td>
</tr>
</tbody>
</table>

☐ I have answered “YES” to 1 or more of the above questions and must complete Page 3.

☐ I have answered “NO” to ALL of the above questions. No TB test is required.

_________________________________________ Date ___________________________
Signature of Student or Parent/Legal Guardian

I have reviewed the above Tuberculosis screening and completed page 3 if required.

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

Date ___________________________ Phone ___________________________
TUBERCULOSIS TESTING

Name: ________________________________ DOB: _____________ University ID #: ___________

Students MUST undergo Tuberculin skin test (TST) OR have one Interferon Gamma Release Assay Test (IGRA). 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. TST

Date placed: _______ Date read: _______ Result: ______ mm  □ Positive  □ Negative

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

B. IGRA (preferred for students who have received BCG vaccine)

Date performed: _______ Result: _______ □ Positive  □ Negative (Attach copy of lab report)

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

C. History of a prior Positive TST or IGRA

Date of positive: _______ Result: ______ mm or attach IGRA report

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 TST or POSITIVE IGRA. 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.

E. Treatment for TB disease of Latent TB Infection

□ Completed  □ Ongoing

Dates of treatment regimen: ___________ to ___________ (attach documentation)

___________________________________________________________

Health Care Provider (printed): __________________________________ Health Care Provider Signature: ____________________________

Date __________________ Phone ________________________
Waiver Information for Meningococcal Disease & Hepatitis B

The Code of Virginia (Chapter 340 23-7.5) requires that “All full time students, prior to enrollment in any public four-year institution of higher education, shall be vaccinated against (i) Meningitis and (ii) Hepatitis B.” Institutions of higher education must provide the student or the student’s parent or other legal representative detailed information on the risks associated with the Meningitis or Hepatitis B, and on the availability and effectiveness of any vaccine. The Code permits “the student or if the student is a minor, the student’s parent or the legal representative to sign a written waiver stating that he/she has received and reviewed the information on Meningitis or Hepatitis B and detailed information on the risks associated with Meningitis or Hepatitis B and on the availability and effectiveness of any vaccine, and has chosen not to be or not to have the student vaccinated.”

<table>
<thead>
<tr>
<th>Hepatitis B</th>
<th>Meningococcal Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B is a potentially fatal disease that attacks the liver. The virus can cause short-term (acute) illness that leads to loss of appetite, tiredness, diarrhea and vomiting, jaundice (yellow skin or eyes) and plain in muscles, joints and stomach. Many people have no symptoms with the illness that leads to liver damage, liver cancer, and death.</td>
<td>Meningococcal disease is the leading cause of bacterial meningitis in children 2-18 years old in the U.S. Meningitis is an infection of the brain and spinal cord coverings. Meningococcal disease can also cause blood infections. According to the Centers for Disease Control, about 1,000-1,200 people get meningococcal disease each year in the U.S. Of those cases, 10-15% die and of those who live, another 11-19% may require limb amputation, have problems with their nervous system, become deaf, or suffer seizures or strokes.</td>
</tr>
<tr>
<td>According to the Centers for Disease Control, about 1.2 million people in the U.S. have chronic Hepatitis B infection. Each year approximately 40,000 people become infected with Hepatitis B virus. Young adults are more likely to contract Hepatitis B infection due to greater likelihood of high-risk behaviors such as multiple sexual partners.</td>
<td>College students, particularly freshmen who live in dormitories, have a 6-fold increased risk of getting meningococcal disease. The disease is spread person-to-person through the exchange of respiratory and throat secretions (e.g., by coughing, kissing, or sharing eating utensils).</td>
</tr>
<tr>
<td>Approximately 3,000 people die from chronic Hepatitis B infection annually in the U.S. It is spread through contact with blood and body fluids of an infected person, such as having unprotected sex with an infected person or sharing needles when injecting illegal drugs. Unvaccinated health-science students are at risk of contracting Hepatitis B through an accidental occupational blood/body fluid exposure.</td>
<td>Meningococcal conjugate vaccine (MCV4) and polysaccharide vaccine (MPSV4) are effective in preventing four types of meningococcal disease including two of the three most commonly occurring types in the U.S. It does not, however, protect against serotype B. Meningitis B vaccine (Trumenba or Bexsero) offers protection for serotype B. Seven outbreaks of serogroup B meningococcal disease have occurred on college campuses since 2009, resulting in 41 cases and 3 deaths (MMWR 64(411); 1171-6).</td>
</tr>
<tr>
<td>There are several ways to prevent Hepatitis B infections including avoiding risky behavior, screening pregnant women, and vaccination. Vaccination is the best prevention. The vaccine series typically consists of three injections given over a six month period.</td>
<td>ACIP recommends routine vaccination of persons with meningococcal conjugate at age 11 or 12 years with a booster dose at age 16. Persons who receive their first meningococcal conjugate vaccine at or after 16 years do not need a booster dose. Routine vaccination of healthy persons older than 21 years who are not at increased risk of exposure to N. meningitides is not recommended.</td>
</tr>
</tbody>
</table>

**Remember: Completion of the vaccine series is needed for protection against Hepatitis B disease.**

For more detailed information please visit: [http://www.cdc.gov/ncidod/diseases/hepatitis/b/faqb.htm](http://www.cdc.gov/ncidod/diseases/hepatitis/b/faqb.htm)

The vaccine is available through your private health provider, most local health departments and University of Virginia Student Health Services.

The vaccine is available through your private health provider, most local health departments and University of Virginia Student Health Services.
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: __________