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

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 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 9/1/2016 (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.

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

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-nr@virginia.edu

MR Office Use Only:
Date Received: ________________________________
Account #: ________________________________

Name: ________________________________________
Birthday: __/__/____

University ID: ____________________________
Phone: ____________________________

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

Name: ________________________________________
Relationship to student: ____________________________

Address: ________________________________________
No. & Street ____________________________
City ____________________________
State ____________________________
Zip/Postal Code ____________________________
Country ____________________________
Telephone:(______)_____________________________
Work/Cell:(______)______________

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 Tuberculosis Screening  All students regardless of enrollment status are required to complete the tuberculosis screening form on page 2.

IMMUNIZATIONS

Diphtheria-Pertussis-Tetanus (DPT) has received ___ doses, last dose given ___/___/____

Tetanus, diphtheria, pertussis (Tdap) within 10 yrs ___/___/____  OR Tetanus diphtheria (Td) within 10 yrs ___/___/____

Hepatitis A

Hepatitis B or Hep A/B (Twinrix)

Human Papillomavirus ___/___/____  OR Gardasil

Measles, mumps, rubella (MMR):

Received after first birthday ___/___/____  OR Measles (Rubeola): ___/___/____

Mumps: ___/___/____  Rubella: ___/___/____

Meningococcal vaccine - students < 22 years of age ___/___/____

Meningitis B ___/___/____  OR Bexsero

Other Immunizations:

Polio IPV or OPV

Date series completed: ___/___/____

Varicella (Chicken Pox) strongly recommended

Date of disease: ___/___/____  OR vaccines ___/___/____  OR vaccines ___/___/____  OR vaccines

2 doses, ≥ 1 mo. apart

Varicella (Chicken Pox) strongly recommended

Date of disease: ___/___/____  OR vaccines ___/___/____  OR vaccines ___/___/____  OR vaccines

2 doses, ≥ 1 mo. apart

= Required

SIGN HERE

Health Care Provider or Health Department Signature ____________________________ Date ____________________________

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 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 ____________________________ Date ____________________________

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 ____________________________ Date ____________________________

RELIGIOUS EXEMPTION

I wish to be exempt from the immunization requirements noted on the University of Virginia Pre-Enrollment Health Record because administration of the vaccine(s) designates 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 [ ]; Hib [ ]; Pneum [ ]; 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 ____________________________ Date ____________________________

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/Tdap [ ]; DT/Td [ ]; OPV/IPV [ ]; Hib [ ]; Pneum [ ]; 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 ____________________________ Date ____________________________
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. 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

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

   □ 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.

   Signature of Student or Parent/Legal Guardian ___________________________ Date _____________

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

   Health Care Provider (printed): ___________________________ Health Care Provider Signature: ___________________________
   Date _____________ Phone ___________________________

   *The significance of the travel exposure should be discussed with a health care provider and evaluated.
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)  
   □ 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.

C. **History of a prior Positive TST or IGRA**
   
   Date of positive TST:________  Result :_____ mm  OR  Date of positive IGRA:_________  □ Quantiferon Gold or □ T-Spot
   
   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 or 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

Please read the following information on Meningococcal Disease and Hepatitis B before signing the waiver on the Certificate of Immunization.

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.”

### Hepatitis B

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.

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.

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.

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.

**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.

### Meningococcal Disease

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.

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).

**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).

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.

In addition to the meningococcal conjugate vaccine, **Meningitis B vaccine** is recommended for high risk students with a history of persistent complement component deficiencies or patients with anatomic or functional asplenia. It may also be given to anyone 16 to 23 years old to provide short-term protection. This can be either a two- or three-shot series depending on the vaccine (Bexsero or Trumenba).

For more detailed information please visit [http://www.immunize.org/catg.d/p4210.pdf](http://www.immunize.org/catg.d/p4210.pdf)

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.

_________________________  __________________________  Date: __________
Student/Parent Signature