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

The form can also be submitted via our secure patient portal: https://www.healthyhoos.virginia.edu (requires NetBadge account). Click on “Upload” and follow the instructions.

Please ensure you have completed all **required** sections listed below prior to submission. **Students with forms received after August 31, 2017 (January 31, 2018 for the spring semester) will be subject to a $100.00 late fee.** The secure patient portal (https://www.healthyhoos.virginia.edu) is 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 secure message on the patient portal.

Please note:

1. **Designated Emergency Contact(s):** 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.
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. **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 9/1/2017 (fall entry) or 1/1/2018 (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 dates of the primary series as well as any boosters received since that date. A titer proving immunity is acceptable; please enter the date of a positive titer and provide a copy of the report showing 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 3) is required for all students. “Tuberculosis Testing” (page 4) is also required for students who answer “yes” to any question on page 3. All screening/testing must be completed on or after 3/1/2017 (fall entry) or 7/1/2017 (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.
Non-Medical or Non-Nursing Student Form

Name: ____________________________________________ First Middle ________________________

University ID: ___________________ Telephone: ____________________________

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

Name: ____________________________________________ Relationship to student: ____________________

Address: ________________________________________________________________________________

No. & Street ____________________________________________________________________ City State Zip/Postal Code Country

Telephone: (______) __________________________ Work/Cell: (______) _____________________________

Long Term Signature Agreement:

( ) ( ) ( )

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

Before submitting to Student Health, please be sure that you are not a Medical or Nursing Student and that:

- A health care provider has completed and signed both the Immunization Record and the Tuberculosis Screening/Testing Forms.
- Titer results are attached (see instructions).
- All documents are on white paper.
- If applicable, waivers have been signed.
- If your child will be a minor on arrival, you have signed the medical consent form.
- Registration for subsequent semesters will be blocked if you do not comply with immunization requirements.

RETURN TO: Department of Student Health
P.O. Box 800760
400 Brandon Avenue, Room 142
Charlottesville, Virginia 22908-0760
Phone: (434) 924-1525; FAX: (434) 982-4262
Website: http://www.virginia.edu/studenthealth/ Email: sth-mr@virginia.edu

Or submit your form via our secure patient portal: https://www.healthyhoos.virginia.edu (requires NetBadge account). Click on “Upload” and follow the instructions.
## Certificate of Immunization

**Name:**

**DOB:**

**University ID #:**

**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 vaccine information before 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 vaccine information before 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-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**

**Date**

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

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**IMMUNIZATIONS**

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

**Hepatitis A**

- ___/___/___
- ___/___/___
- ___/___/___
- ___/___/___

**Hepatitis B or Hep A/B (Twinrix)**

- ___/___/___
- ___/___/___
- ___/___/___
- ___/___/___

**Varicella**

- ___/___/___
- ___/___/___
- ___/___/___
- ___/___/___

**Measles, Mumps, Rubella (MMR):**

- Received after first birthday ___/___/___
- OR Measles (Rubeola): ___/___/___
- OR Mumps: ___/___/___
- OR Rubella: ___/___/___

**Meningococcal vaccine-students under 22 years of age**

- ___/___/___
- ___/___/___
- ___/___/___
- ___/___/___

**Meningitis B**

- ___/___/___
- ___/___/___
- ___/___/___
- ___/___/___

**Other Immunizations:**

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**Polio:**

- OPV alone (oral Sabin 3 doses) #1/___/___ #2/___/___ #3/___/___
- IPV/OPV sequential #1/___/___ #2/___/___ #3/___/___ #4/___/___
- IPV alone #1/___/___ #2/___/___ #3/___/___ #4/___/___
- (injected Salk four doses)

**Tetanus, diphtheria, pertussis (Td) within 10 yrs**

- ___/___/___
- OR Tetanus diphtheria (Td) within 10 yrs ___/___/___

**Varicella (Chicken Pox) strongly recommended Date of disease: ___/___/___

- OR vaccines ___/___/___
- OR Tdap ___/___/___

**OR**

- OR titers indicative positive immunity Must attach lab results.

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

As specified in the Code of Virginia §23.1-800, 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
- OPV/OPV
- Measles
- Rubella
- Mumps
- Hepatitis B
- Hepatitis A
- 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**

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**Health Care Provider or Health Department Signature**

**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 4).
   ☐ 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, employee and/or volunteer 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 or volunteer?
   ☐ 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

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

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

   *Patient has answered “YES” to 1 or more of the above questions; health care provider must complete Page 4.
   ☐ Patient has answered “NO” to ALL of the above questions. No TB test or completion of page 4 is required.

   - Afghanistan
   - Algeria
   - Angola
   - Argentina
   - Armenia
   - Azerbaijan
   - Bangladesh
   - Belarus
   - Belize
   - 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
   - India
   - Indonesia
   - Iraq
   - Kazakhstan
   - Kenya
   - Kiribati
   - Kuwait
   - Kyrgyzstan
   - Lao People’s Democratic Republic
   - Latvia
   - Lesotho
   - Liberia
   - Libya
   - Lithuania
   - Madagascar
   - Malawi
   - Malaysia
   - Maldives
   - Mali
   - Marshall Islands
   - Mauritania
   - Mauritius
   - Mexico
   - Micronesia (Federated States of)
   - Mongolia
   - Montenegro
   - Morocco
   - Mozambique
   - Myanmar
   - Namibia
   - Nauru
   - New Caledonia
   - Nepal
   - Nicaragua
   - Niger
   - Nigeria
   - Northern Mariana Islands
   - Pakistan
   - Palau
   - Panama
   - Papua New Guinea
   - Paraguay
   - Peru
   - Philippines
   - Portugal
   - Qatar
   - Republic of Korea
   - Republic of Moldova
   - Romania
   - Russian Federation
   - Rwanda
   - Sao Tome and Principe
   - Senegal
   - Serbia
   - Sierra Leone
   - Singapore
   - Solomon Islands
   - Somalia South Africa
   - South Sudan
   - Sri Lanka
   - Sudan
   - Suriname
   - Swaziland
   - Syrian Arab Republic
   - Tajikistan
   - Thailand
   - Timor-Leste
   - Togo
   - Tunisia
   - Turkmenistan
   - Tuvalu
   - Uganda
   - Ukraine
   - United Republic of Tanzania
   - Uruguay
   - Uzbekistan
   - Vanuatu
   - Venezuela (Bolivarian Republic of)
   - Viet Nam
   - Yemen
   - Zambia
   - Zimbabwe

I have reviewed the above Tuberculosis screening (and completed and signed page 4 if required).

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

Date ______________________ Phone ______________________
TUBERCULOSIS TESTING

Name: ____________________________________________  DOB: _____________  University ID #:_____________

Students MUST undergo one Interferon Gamma Release Assay Test (IGRA) OR one Tuberculin Skin Test (TST). 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. **IGRA (recommended 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.

B. **TST**

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

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

C. **History of a prior Positive IGRA or TST - TB Symptom Survey required**

   Date of positive IGRA:________  Result :_____ mm □ Quantiferon Gold or □ T-Spot  OR Date of positive TST:________

   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 IGRA or POSITIVE TST. 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 in English.

E. **Treatment for TB disease or Latent TB Infection**

   □ Completed  □ Ongoing

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

   Date of chest x-ray obtained prior to treatment: __________  □ Positive  □ Negative

Health Care Provider (printed):_________________________  Health Care Provider Signature:____________________

Date____________________  Phone____________________