Dear New University of Virginia Medical or Nursing 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.

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:** 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 for a medical reason (TB testing is still required). For medical and nursing students, exemption may result in modification of clinical educational activities.

5. **Certificate of Immunization & Tuberculosis Testing:** To be completed at a visit by your healthcare provider. All medical and nursing students require tuberculosis testing. **All elements of tuberculosis testing must have been completed on or after 3/1/2017 (fall entry) or on or after 7/1/2017 (spring entry).**

Sincerely,

Christopher Holstege, M.D.
Executive Director
Department of Student Health
INSTRUCTIONS FOR COMPLETING MEDICAL/NURSING IMMUNIZATION INFORMATION

Marking: Please print using black ink. Read carefully and fill in all applicable information. All information regarding Immunization and Tuberculosis testing must be in English.

Certificate of Immunization and Tuberculosis Testing: To be completed and signed by a Health Care Provider

Required vaccinations/testing:

A. Tetanus/Diphtheria/Pertussis Booster: Primary series (DTap, DTP, DT or Td) plus booster within the last 10 years of 9/1/2017 for fall entry and 1/1/2018 for spring entry. Must have received one adult dose of Tdap. 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. Required regardless of birthdate. 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 provide a copy of the report with the date and result of positive titer.

D. Hepatitis B: Medical and nursing students must have documentation of a completed vaccination series and serologic confirmation of immunity. Attach copy of quantitative lab report. If the titer is negative, management depends on the time that has elapsed between the completion of the series and the date of the negative titer. Most students will have completed the initial hepatitis series months to years before the titer. In this case, the student needs one booster then a repeat titer in 1-2 months. If the titer remains negative, the student needs to complete the second series then repeat a titer in 1-2 months. In the rare situation in which a student has a negative titer drawn within 1-2 months of completing the initial series, the student needs to complete the entire second series then repeat a titer in 1-2 months.

E. Meningococcal Vaccine: For students younger than 22 years of age, one dose of vaccine required after age 16 or signed waiver. Conjugate vaccine (Menactra or Menveo) is preferred. Meningitis B vaccine (Trumenba and Bexsero) does not meet this requirement.

F. Varicella (chicken pox): Two doses of vaccine, at least 4 weeks apart, or serological confirmation of immunity. Attach copy of lab report.

G. Tuberculosis Testing: All medical and nursing students are required to complete tuberculosis testing. See page 2 for instructions. All elements of this requirement must have occurred on or after 3/1/2017 for fall entry or 7/1/2017 for spring entry. All documentation from multiple institutions must be recorded on the Tuberculosis Testing form and validated by a care provider. A chest x-ray alone will not satisfy this requirement.

Recommended vaccinations for all students:

A. 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.

B. HPV Vaccine: The three-shot series is recommended for all females ages 11-26 and males ages 11-21. It is also approved for males up to age 26 in certain situations, see CDC guidelines.

C. 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 to 23 years old to provide short-term protection. This can be either a two-or three-shot series depending upon the vaccine (Bexsero or Trumenba). The same vaccine must be used for all doses; Student Health only stocks Bexsero.

Influenza Vaccine Requirements:

- All medical and nursing students are required to have an annual seasonal influenza vaccine each fall. Influenza clinics will be planned by Student Health to provide the vaccine early in the fall semester. Students will receive a sticker for his/her name badge which signifies compliance. Student Health will work with the Schools of Medicine and Nursing to monitor compliance.

- Failure to comply with influenza vaccine requirements may result in the inability to participate in clinical rotations and exclusion from patient contact.

- Medical waivers for this requirement may only be granted by Student Health.
MEDICAL AND NURSING STUDENT FORM

Name:________________________________________________________________________
Last               First                         Middle

Birthday: __________/________/________
Month      Day      Year

University ID:_______________________ Telephone:________________________________________

Term Entering: □ Fall □ Spring

Emergency Contact: (Parent/Guardian/Spouse/Next-of-Kin)
Name:________________________________________________________________________
Last               First                         Middle

Relationship to student: ___________________________________________________________

Address:________________________________________________________________________
No. & Street                  City                        State                        Zip/Postal Code

Telephone:(______)_____________________________ Work/Cel:(______)_____________________________

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:

• A health care provider has completed and signed both the Immunization Record and the Tuberculosis 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 at our secure website: https://www.healthyhoos.virginia.edu (requires NetBadge account). Click on “Upload” and follow the instructions.
# Certificate of Immunization

## Medical or Nursing Students

**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-mr@virginia.edu

**University ID #:**

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**Name:**  
Last:  
First:  
Middle:  
DOB: _____________

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**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.**

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**R** = Required

**R Tuberculosis Testing** All medical and nursing students are required to complete the Tuberculosis Testing form on page 3.

### IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria-Pertussis-Tetanus (DPT)</td>
<td>has received doses, last dose given</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>has received doses, last dose given</td>
</tr>
<tr>
<td>Hepatitis B (or Hep A/B) (Twinrix)</td>
<td>titer indicating immunity. Must attach quantitative lab results.</td>
</tr>
<tr>
<td>Rubella</td>
<td>has received doses, last dose given</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (MMR)</td>
<td>has received doses, last dose given</td>
</tr>
<tr>
<td>Mumps</td>
<td>has received doses, last dose given</td>
</tr>
<tr>
<td>Meningococcal vaccine – students</td>
<td>□ Menactra (recommended)</td>
</tr>
<tr>
<td>Meningococcal vaccine – &lt;2 years of age</td>
<td>□ Menveo (recommended)</td>
</tr>
<tr>
<td>Meningitis B</td>
<td>□ Menomune</td>
</tr>
<tr>
<td>Polio</td>
<td>□ Bexsero</td>
</tr>
<tr>
<td>Polio (oral Sabin 3 doses)</td>
<td>□ Trumenba</td>
</tr>
<tr>
<td>Polio (IPV sequential)</td>
<td></td>
</tr>
<tr>
<td>Polio (IPV alone)</td>
<td></td>
</tr>
<tr>
<td>Tetanus, diphtheria, pertussis (Tdap)</td>
<td>within 10 yrs.</td>
</tr>
<tr>
<td>Varicella (Chicken Pox)</td>
<td></td>
</tr>
</tbody>
</table>

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**R** Influenza: Required annually after enrollment with the seasonal vaccine. Student may obtain through Student Health in the fall.

### Signature of Medical Provider/Health Department Official

**Date**

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**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

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**Meningococcal Vaccine Waiver**

Review vaccine information before signing:  
http://www.imunize.org/vis/meningococcal_mcv_mpsv.pdf

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

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**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

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**Medical Exemption**

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
- DT/Td
- OPV/IPV
- 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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**MR Office Use Only:**

**Date received:**

**Account #:**

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**Department of Student Health**

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**Page 2 of 3**  
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TUBERCULOSIS TESTING
MEDICAL AND NURSING STUDENTS

Name: _______________________________________
DOB: ___________________ University ID #: __________

Last                                                      First
Middle

Students MUST have one Interferon Gamma Release Assay Test (IGRA) OR a two- or three-step 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

History of BCG vaccination? (If yes, consider IGRA if possible) □ Yes □ No Date: __________
Birth Country: ______________

A. IGRA (recommended 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 or three-step TST.

B. Two-Step TST -- The first TST should be read 48–72 hours following placement. The second must be placed no less than 7 days and not more than 3 months from the reading from the first, or both steps must be repeated.

Test 1: Date placed:__________ Date read:__________ Result:______ mm □ Positive □ Negative
Test 2: Date placed:__________ Date read:__________ Result:______ mm □ Positive □ Negative

Three-Step TST – There must be no less than 7 days between first placement and first reading. The second test is placed the same day as the first reading and should be read within 48-72 hours.

Test 1: Date placed:__________ Date read:__________ Result:______ mm □ Positive □ Negative
Test 2: 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: ____________ □ 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_____________________

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