UNIVERSITY of VIRGINIA
STUDENT HEALTH

Fall 2016 and Spring 2017

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 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.

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 4).
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. **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 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 3/1/2016 (fall entry) or on or after 7/1/2016 (spring entry).**

Sincerely,

Christopher Holstege, M.D.
Executive Director
Department of Student Health

University of Virginia
Department of Student Health

Entire form due August 31, 2016 for Fall or January 31, 2017 for Spring to avoid $100 processing fee.

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 9/1/2016**. 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. **Rubella Antibody Titer**: A rubella titer is **required** for medical and nursing students and must prove immunity. Please provide a copy of the report with the date and result of positive titer.

D. **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 a copy of the report with the date and result of positive titer.

E. **Hepatitis B:** Medical and nursing students must have documentation of a completed vaccination series **and** serologic confirmation of immunity. The Twinrix immunization series is an acceptable alternative to the vaccination series. Attach copy of **quantitative** lab report. If the titer is negative after the initial Hepatitis B series, repeat the series. If the titer is negative after the repeated series, contact the Nursing Supervisor at Elson Student Health Center for recommendations on re-vaccination.

F. **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.

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

H. **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 3/1/2016 for fall entry or 7/1/2016 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.

University of Virginia
Department of Student Health

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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

MR Office Use Only:
Date received: _____
Account #: _____

Name: _____ Birthday: ____/____/____
Last First Middle Month Day Year

University ID:_____ Telephone:_____ Country of Origin:_____

Emergency Contact: (Parent/Guardian/Spouse/Next-of-Kin) Term Entering: □ Fall □ Spring

Name:_____ Relationship to student: _____
Last First Middle

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 Testing** All medical and nursing students are required to complete the Tuberculosis Testing form on page 2.		
IMMUNIZATIONS			
	Diphtheria-Pertussis-Tetanus (DPT) has received ___ doses, last dose given ____/___/___		
	Hepatitis A ① ____/___/____ ② ____/____/____		
R	**Hepatitis B** ① ____/___/____ ② ___/____/____ ③ ___/____/____		**AND** titer indicating immunity. **Must attach quantitative lab results.**
R	**or Hep A/B (Twinrix)** ① ____/___/____ ② ___/____/____ ③ ___/____/____		
	Human Papillomavirus ① ____/____/____ ② ____/____/____ ③ ____/____/____		□ Gardasil □ Cervarix
R	**Influenza:** Required annually after enrollment with the seasonal vaccine. Student may obtain through Student Health in the fall.		
R	**Measles, mumps, rubella (MMR):** ① ____/____/____ ② ____/____/____ Received after first birthday		**OR** titer(s) indicating positive immunity **Must attach lab results.**
R	**OR** **Measles (Rubeola)**: ①____/____/____ ②___/____/____ **Mumps:** ①____/____/____ ②___/____/____ **Rubella:** ①____/____/____ ②___/____/____		
R	**Rubella antibody titer:** ____/___/____	**Must attach lab results indicating immunity.**	
R	**Meningococcal vaccine** – students <22 years of age ① ___/____/____ ② ___/____/____	**OR** waiver signed	□ MCV4 given □ MPS4 given
	Meningitis B ① ___/____/____ ② ___/____/____ ③ ___/____/____		□ Bexsero □ Trumenba
R	**Polio IPV or OPV** Date series completed: ___/____/____	**OR** titer indicating positive immunity	**Must attach lab results.**
R	**Tetanus, diphtheria, pertussis (Tdap)** within 10 yrs. ____/____/____		
R	**Varicella (Chicken Pox)** ① ___/____/____ ② ___/____/____ must have 2 doses, ≥ 1 month apart		**OR** titer indicating immunity. **Must attach lab results.**
R	= Required		

_____
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

Meningococcal Vaccine Waiver
(Review page 3 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-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) Testing**

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

University of Virginia
Department of Student Health

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TUBERCULOSIS TESTING
MEDICAL AND NURSING STUDENTS

Name: _____ DOB: _____ University ID #:_____

Students **MUST** undergo a two-step 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. **Two-Step TST**: **must have at least 7 days, but not more than 3 months, between 1st reading and 2nd placement or the series must be repeated.**

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, 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_____

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Waiver Information for Meningococcal Disease

Please read the following information on Meningococcal Disease 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 Meningococcal Disease." 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 Meningococcal Disease, 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 Meningococcal Disease and detailed information on the risks associated with Meningococcal Disease and on the availability and effectiveness of any vaccine, and has chosen not to be or not to have the student vaccinated."

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. 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

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

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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