Student Name: ________________________________ DOB: ____/____/______ University ID #:____________________

Entire Form due 8/1/24 (Fall), or 1/31/25 (Spring) to avoid $100 late fee.

Pre-Entrance Health Form: PART I

[TO BE COMPLETED BY INCOMING STUDENT OR PARENT/LEGAL GUARDIAN]

Student Name: ____
Last First Middle

Date of Birth: ____/____/______ University ID# __________________________ State or Country of Birth: _________________

Address: ____
Street City State Zip

Student Cell Phone _____-_____-_____ Student Alternate Phone Number _____-_____-_____ (☐ home ☐ work)

Name of Parent or Legal Guardian 1: _________________________ Phone _____-_____-_____ Work or Cell _____-_____-_____

Name of Parent or Legal Guardian 2: _________________________ Phone _____-_____-_____ Work or Cell _____-_____-_____

Emergency Contact: ______________________________________ Phone _____-_____-_____ Work or Cell _____-_____-_____

Long Term Signature Agreement

To be completed by the student or parent/legal guardian if student is under 18 years of age. Signing this Long-Term Signature Agreement assures that relevant information can be sent to your insurance company if insurance claims are filed on your behalf.

I hereby assign the benefits of my insurance policy to the University of Virginia Department of Student Health and Wellness 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:** ___/___/____

Consent for the Treatment of Minors

To be completed by parents or legal guardians of students who will be under 18 years of age when arriving on Grounds.

The University of Virginia Department of Student Health and Wellness has my permission to treat my minor child in the event of a medical emergency. The University of Virginia Department of Student Health and Wellness also has my permission to treat my child for routine medical care, including check-ups, immunizations, and/or treatment for minor injuries and illnesses.

Student/Parent Signature: ____ **Date:** ___/___/____

Alert: Health Insurance Verification Program

The University of Virginia requires all students charged the comprehensive fees with tuition to have health insurance that meets specific coverage requirements (i.e., comparable coverage). Proof of insurance for the Health Insurance Verification Program must be submitted online between July 15, 2024, and August 30, 2024, (Fall) in order to meet this requirement at the following address: https://www.studenthealth.virginia.edu/insurance-deadlines

If proof of comparable coverage is not submitted (whether a student fails to submit any documentation or because a student's health plan is determined not to provide adequate comparable coverage), the student will be responsible for the full cost for single coverage under the University-endorsed Student Health Insurance plan. For more information: https://www.studenthealth.virginia.edu/about/insurance

Student Name: ______________________________ DOB: ____/____/______ University ID #:____________________

Entire Form due 8/1/24 (Fall), or 1/31/25 (Spring) to avoid $100 late fee.

Pre-Entrance Health Form: PART II

[TO BE COMPLETED BY INCOMING STUDENT OR PARENT/LEGAL GUARDIAN IF UNDER 18]

Tuberculosis (TB) Screening Questionnaire:

Have you ever had close contact to someone with infectious TB disease at any time? ☐ YES ☐ NO

Have you had a previous positive TB test? ☐ YES ☐ NO

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ☐ YES ☐ NO

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? ☐ YES ☐ NO

Do you have a suppressed immune system (ex. HIV infection, injection drug use, organ transplant recipient, treatment with immunosuppressant medication)? ☐ YES ☐ NO

Do you have a medical condition with increased risk for progression to TB disease (ex. body weight < 10% ideal, silicosis, diabetes, chronic renal failure, gastrectomy, jejunoileal bypass, solid organ transplant, head/neck cancer)? ☐ YES ☐ NO

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? ☐ YES ☐ NO
If yes, which country or territory? ____

Have you lived or traveled for 1-3 months or more in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please **CIRCLE** the country or countries below.) ☐ YES ☐ NO

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

I affirm that all of the above information is accurate.

Student/Parent Name: ______________________________ **Signature**: ___________________________ **Date**: _____________

In lieu of completing the above Part II on paper, students may complete online: https://www.healthyhoos.virginia.edu.
Click on "forms" and select "HealthyHoos TB Screening Questionnaire."

Student Name: ________________________________ DOB: ____/____/______ University ID #:____________________

Entire Form due 8/1/24 (Fall), or 1/31/25 (Spring) to avoid $100 late fee.

Pre-Entrance Health Form: PART III

[TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER.]

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form. For more information about immunization requirements or exemption forms: https://www.studenthealth.virginia.edu/pre-entrance-health-requirements

Required Vaccines	Record Complete Dates (mm/dd/yyyy) of Vaccine Doses Given			
Polio (IPV, OPV)	1	2	3	4
Measles, Mumps, Rubella (MMR) Vaccine	1	2	First dose must be on or after first birthday. If dose was too early, provide booster or obtain serologic confirmation of immunity.	
Measles (Rubeola)	1	2	Or date of Serologic Confirmation of Measles Immunity (must attach copy of lab result):	
Rubella	1		Or date of Serologic Confirmation of Rubella Immunity (must attach copy of lab result):	
Mumps	1	2	Or date of Serologic Confirmation of Mumps Immunity (must attach copy of lab result):	
Meningococcal Vaccine (A, C, Y, W) (initial or booster dose must be on or after 16th birthday) Required only for students < 22 years of age.	1		**Please Note**: Serogroup B Meningococcal Vaccine does **not** meet this requirement.	
Tetanus Booster ☐ Td ☐ Tdap	1	**Alert: Tetanus booster (Td or Tdap) is required in the last 10 years.** After September 1, 2014 (Fall) or January 1, 2015 (Spring).		
Hepatitis B Vaccine ☐ 2-dose vaccine used to complete series.	1	2	3	Or date of Serologic Confirmation of Hepatitis B Immunity (must attach copy of lab result):

Recommended Vaccines	Record Complete Dates (mm/dd/yyyy) of Vaccine Doses Given			
Hepatitis A	1	2		
Human Papillomavirus Vaccine (HPV)	1	2	3	
Serogroup B Meningococcal Vaccine ☐ MenB-4C ☐ MenB-FHpb	1	2	3	
Varicella	1	2	Or date of Varicella Disease or Serologic Confirmation of Varicella Immunity (must attach copy of lab result): ____________	
COVID-19 Vaccine Please list the date of your most recent vaccine	1			

Required Tuberculosis Screening (all students): All steps must be after 3/1/24 (Fall) or 7/1/24 (Spring)				
Tuberculosis Screening Questionnaire Result (see page 2)	☐ Positive (any questionnaire response of "yes")	☐ Negative (all questionnaire responses "no")		
Tuberculosis Testing Result**. Required only if TB Screening Questionnaire Result Positive.** IGRA **required** for students from any country listed on page 2. IGRA preferred for all other students.	Result: ☐ Positive ☐ Negative	Test method: ☐ IGRA ☐ PPD	Date of Test:	Must attach copy of result for IGRA.
Chest X-ray result. **Required only if Tuberculosis Testing Result Positive.**	☐ Positive	☐ Negative	Date of test:	Must attach copy of report.
All students with a positive IGRA or TST and no signs of active disease on chest x-ray should receive education and treatment recommendations for Latent Tuberculosis Infection (LTBI). LTBI must be reported in VA: http://www.vdh.virginia.gov/tuberculosis/				

TO BE COMPLETED BY HEALTH CARE PROVIDER:

Signature of Medical Provider/Health Department Official: ____

Medical Provider's Printed Name: ____ **Date:**________________

Address: ____ **Phone:** ____-____-_____