



Fall 2018 and Spring 2019

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 uploading to our secure website or 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

To upload the form 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, 2018 (January 31, 2019 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. **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.
2. **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.
3. **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).
4. **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

REQUIRED VACCINES

The following instructions are adapted from the American College Health Association Guidelines. These guidelines follow Advisory Committee on Immunization Practices (ACIP) recommendations published by the U.S. Centers for Disease Control and Prevention (CDC). Links to full information regarding ACIP provisional and final recommendations, including schedules, indications, precautions, and contraindications, are available at the CDC National Immunization Program website: <http://www.cdc.gov/vaccines/index.html>. ACHA Guidelines for Tuberculosis Screening and Targeted Testing of College and University Students are available at www.acha.org/guidelines.

MEASLES, MUMPS, RUBELLA (MMR) VACCINE

VACCINATION SCHEDULE: Two doses of MMR at least 28 days apart after 12 months of age.

MAJOR INDICATIONS:

- **All college students born after 1956 without laboratory evidence of disease.**
- All health care professional students without other evidence of immunity should receive two doses of MMR.
- **Those born before 1957 without other evidence of immunity should receive one dose if not in an outbreak setting and two doses if in an outbreak.**

CONTRAINDICATIONS AND PRECAUTIONS: Pregnancy, history of hyper-sensitivity or anaphylaxis to any of the components in the vaccine. Receipt of blood products and moderate or severe acute infections. Guidelines exist for vaccination of persons with altered immunocompetence.

MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135) VACCINE

- Conjugate (Preferred)
- Polysaccharide (Acceptable alternative if conjugate not available)

VACCINATION SCHEDULE:

- Initial dose of conjugate vaccine: 11-12 yrs of age
- Booster dose: 16 yrs of age
- If initial dose given age 13-15 yrs: booster dose at 16-18 yrs of age
- If initial dose given age ≥ 16 yrs, no booster dose required

Persons with persistent complement component deficiencies or asplenia should receive a 2-dose primary series administered 2 months apart and then receive a booster dose every 5 years. Adolescents aged 11 through 18 years with HIV infection should be routinely vaccinated with a 2-dose primary series. Other persons with HIV who are vaccinated should receive a 2-dose primary series administered 2 months apart. All other persons at increased risk for meningococcal disease (e.g., microbiologists or travelers to an epidemic or highly endemic country) should receive a single primary dose.

For colleges and university with meningococcal vaccine policies as a requirement of enrollment or on-campus living: students 21 years of age and younger should have documentation of a dose of conjugate vaccine at ≥ 16 years of age. The booster dose can be administered any time after the 16th birthday. The minimum interval between doses of meningococcal conjugate vaccine is 8 weeks.

Routine vaccination of healthy persons who are not at increased risk for exposure is not recommended after age 21 years.

MAJOR INDICATIONS:

Adolescents 11-18 years of age and other populations at increased risk, including college students living in residence halls/similar housing, etc., persons with persistent complement deficiencies or asplenia, laboratory personnel with

exposure to aerosolized meningococci, and travelers to hyperendemic or endemic areas of the world. Non-freshmen college students may choose to be vaccinated to reduce their risk of meningococcal disease.

CONTRAINDICATIONS AND PRECAUTIONS:

History of hypersensitivity or serious adverse reaction to any of the components in the vaccine.

Avoid vaccinating persons who are known to have experienced Guillain-Barre (GBS) syndrome.

There is a theoretical risk of increased rates of local or systemic reactions when two diphtheria toxoid -containing vaccines are administered within a short interval (i.e., on different days). Efforts should be made to administer Tdap and tetravalent meningococcal conjugate (MCV4) vaccines simultaneously if both are indicated. If simultaneous vaccination is not feasible, Tdap and MCV4 vaccines (which contain diphtheria toxoid) can be administered in any sequence.

TETANUS, DIPHTHERIA, PERTUSSIS VACCINE

- DT: pediatric (<age 7 years) preparation of diphtheria and tetanus toxoids.
- DTaP: pediatric (<age 7 years) preparation of diphtheria, tetanus toxoids, and acellular pertussis.
- DTP (also known as DTwP): pediatric (<age 7 years) preparation of diphtheria, tetanus toxoids, and whole cell pertussis (no longer available in the U.S.).
- Td: 7 years and older preparation of tetanus toxoid and reduced diphtheria toxoid.
- Tdap: adolescent and older preparation of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis.

VACCINATION SCHEDULE:

Primary series in childhood (4 doses: DT, DTaP, DTP, or Td)

Booster doses: For adolescents 11–18 and adults 19–64: single dose of Tdap. Tdap can be administered regardless of interval since the last tetanus or diphtheria toxoid-containing vaccine.

Routine booster dose intervals: Adults should receive Td boosters at 10 year intervals, beginning 10 years after receiving Tdap.

Tetanus prophylaxis in wound management: For all age groups, patients who require a tetanus toxoid containing vaccine as part of wound management should receive Tdap instead of Td if they have not previously received Tdap. If Tdap is not available or was administered previously, Td should be administered.

MAJOR INDICATIONS: One dose of Tdap required on or after 10th birthday. If last Tdap is more than 10 years old, provide date of last Td or Tdap (must be within the last 10 years; after 9/1/2008 for fall or 1/1/2009 for spring).

CONTRAINDICATIONS AND PRECAUTIONS:

History of hypersensitivity or serious adverse reaction to any of the components in the vaccine.

There is a theoretical risk of increased rates of local or systemic reactions when two diphtheria toxoid –containing vaccines are administered within a short interval (i.e., on different days). Efforts should be made to administer Tdap and tetravalent meningococcal conjugate (MCV4) vaccines simultaneously if both are indicated. If simultaneous vaccination is not feasible, Tdap and MCV4 vaccines (which contain diphtheria toxoid) can be administered in any sequence.

HEPATITIS B VACCINE

VACCINATION SCHEDULE: Given as a series of 3 age appropriate doses (given at 0, 1–2 mo., and 6–12 mo.) at any age. Adolescents ages 11–15 years can be given 2 adult doses (given at 0 and 4-6 mo.) *

MAJOR INDICATIONS: All college students. In particular, students enrolled in health care professional programs should receive Hepatitis B vaccination.

CONTRAINDICATIONS AND PRECAUTIONS: History of hypersensitivity to any of the components of the vaccine.

**Combined hepatitis A and B vaccines may be given as a series of 3 doses (given at 0, 1 -2, and 6-12 mo.) for 18 years of age and older.*

POLIO VACCINE

- Inactivated (IPV)
- Oral poliovirus (OPV no longer available in U.S.)

VACCINATION SCHEDULE: Primary series in childhood with IPV alone, OPV alone, or IPV/OPV sequentially; IPV booster only if needed for travel after age 18 years.

MAJOR INDICATIONS: IPV for certain international travelers to areas or countries where polio is epidemic or endemic.

CONTRAINDICATIONS AND PRECAUTIONS: History of hypersensitivity to any of the components of the vaccine.

TUBERCULOSIS SCREENING/TESTING: “Tuberculosis Screening” is required for all non-health sciences students. “Tuberculosis Testing” is also required for students who answer “yes” to any question on Tuberculosis Screening. **All screening/testing must be completed on or after 9/1/2017 (fall entry) or 1/1/2018 (spring entry).**

OTHER VACCINES RECOMMENDED FOR ADULTS

The following vaccines are recommended for adults. College matriculation provides the opportunity to assure that students receive the appropriate vaccines.

INFLUENZA VACCINE

- Inactivated influenza vaccines: Trivalent (IIV3) or Quadrivalent (IIV4) or Recombinant (RIV3)
- Live attenuated influenza vaccine (LAIV; licensed for healthy, nonpregnant persons age 2-49 years) *

VACCINATION SCHEDULE: Annually (recommendation applies to any and all flu vaccines)

MAJOR INDICATIONS:

All members of a campus community age 6 months or older should receive annual vaccination.

College students at high risk of complications from the flu due to asthma, diabetes, or certain immuno-deficiencies; and students with contact with a high-risk individual.

Students enrolled in health care professional programs should receive annual influenza vaccination.

CONTRAINDICATIONS AND PRECAUTIONS: History of hypersensitivity to any of the components of the vaccine)
Note that persons allergic to eggs may safely receive flu vaccines.

**CDC's ACIP is not currently recommending use of LAIV due to lack of effectiveness.*

VARICELLA VACCINE

VACCINATION SCHEDULE: Two doses of varicella-containing vaccine at least 12 weeks apart if vaccinated between 1 and 12 years of age and at least 4 weeks apart if vaccinated at age 13 years or older.

MAJOR INDICATIONS:

- All college students without other evidence of immunity (e.g., born in the U.S. before 1980, a history of disease, two prior doses of varicella vaccine, or a positive antibody).
- All health care professional students with only one documented dose of vaccine or with a negative antibody titer should receive a total of two doses of vaccine.

CONTRAINDICATIONS AND PRECAUTIONS: Pregnancy, history of hyper-sensitivity or anaphylaxis to any of the components in the vaccine, and severe illness. Guidelines exist for vaccination of persons with altered immunocompetence.

HEPATITIS A VACCINE

VACCINATION SCHEDULE: Given as a series of 2 doses (given at 0, 6–12 mo.) for age 12 months or greater. *

MAJOR INDICATIONS: Recommended for routine use in all adolescents through the age of 18 and in particular for adolescent and adult high-risk groups (i.e., persons traveling to countries where hepatitis A is moderately or highly endemic, men who have sex with men, users of injectable and non-injectable drugs, persons who have clotting-factor disorders, persons working with nonhuman primates, and persons with chronic liver disease).

CONTRAINDICATIONS AND PRECAUTIONS: History of hypersensitivity to any of the components of the vaccine.

**Combined hepatitis A and B vaccines may be given as a series of 3 doses (given at 0, 1-2, and 6-12 mo.) for 18 years of age and older.*

SEROGROUP B MENINGOCOCCAL VACCINE

- MenB-4C (Bexsero[®], 2 dose series)
- MenB-FHbp (Trumenba[®], 2 or 3 dose series)

VACCINATION SCHEDULE:

- For MenB-4C: 0–2 months (Category A or B below)
- For MenB-FHbp: 0–2–6 months (Category A below), or 0–6 months (Category B below)

MAJOR INDICATIONS: Category A: Should be administered to persons at increased risk due to:

- Outbreaks of serogroup B meningococcal disease
- Persistent complement component deficiencies
- Treatment with eculizumab for hemolytic uremic syndrome or paroxysmal nocturnal hemoglobinuria
- Anatomic or functional asplenia including sickle cell disease

• Laboratory workers routinely exposed to isolates of *N. meningitis* [Category A: Recommendations made for all persons in age or risk-factor group.]

Category B: May be administered to:

- Adolescents and young adults age 16–23 for short term protection (preferred age 16–18)
- Serogroup B vaccines may be administered with Men ACW but at different anatomic site, if possible.

[Category B: Recommendations are made through consultation and discussion between the individual and their health care provider.]

CONTRAINDICATIONS AND PRECAUTIONS:

- Defer in pregnant or lactating females unless at increased risk.
- History of hypersensitivity to any of the components of the vaccine.
- MenB-4 (Bexsero[®]): use with caution if hypersensitive to latex.
- The two vaccines are not interchangeable, so the same product must be used for all doses.

HUMAN PAPILLOMAVIRUS (HPV) VACCINE

- 9-valent (HPV9) [Bivalent (HPV2) and Quadrivalent (HPV4) are no longer available]

VACCINATION SCHEDULE:

The 9-valent vaccine may be used to complete the series begun with a different product.

All persons 11-14 years: 2 doses separated by at least 6 months; may start at age 9 for increased risk groups

If no prior HPV vaccine given:

- Women ages 15 to 26 years: 3 doses
- Men ages 15 to 21 years: 3 doses
- Men ages 15 to 26 years who have sex with men (MSM): 3 doses
- Transgender and gender non-conforming persons ages 15 to 26 years: 3 doses
- Men ages 15 to 26 years with HIV or other immune compromising conditions: 3 doses
- May be given to men ages 21-26

Historical Vaccine Schedule (The following vaccines are no longer available and have been replaced by the 9-valent vaccine):

- *Bivalent vaccine: for people assigned female at birth, three doses at 0, 1, and 6 months*
- *Quadrivalent vaccine: people assigned female at birth, 11 to 26 years old; and people assigned male at birth, 11 to 21 years old, three doses at 0, 1-2, and 6 months*

MAJOR INDICATIONS:

All 11-or 12-year olds; may be started at age 9.

If not vaccinated previously: women through age 26 and men through age 21.

If not vaccinated previously:

- Young men through age 26 who have sex with men, including those who identify as gay or bisexual or who intend to have sex with men;
- Young adults through age 26 who are transgender or gender non-conforming; and
- Young adults through age 26 with certain immunocompromising conditions (including HIV).

The HPV vaccines are indicated for prevention of cervical cancers in women and for use in both females and males for the prevention of pre-cancers and genital warts, anal cancer, and anal intraepithelial dysplasia caused by HPV types included in the vaccine. No HPV or Pap test screening is required prior to administering vaccine; routine cervical cancer screening should continue according to current recommendations.

CONTRAINDICATIONS AND PRECAUTIONS: Pregnancy, history of hyper-sensitivity to yeast or to any vaccine component; moderate or severe acute illnesses (defer vaccine until improved); may be given to immunocompromised males and females but vaccine responsiveness and efficacy may be reduced.

PNEUMOCOCCAL VACCINE

- Pneumococcal conjugate vaccine (PCV13, Prevnar13)
- Pneumococcal Polysaccharide Vaccine-23 (PPSV23, Pneumovax 23)

VACCINATION SCHEDULE: Childhood, adolescence, adulthood

MAJOR INDICATIONS: Adults with certain medical conditions (see Appendix A); adults age 65 and older

CONTRAINDICATIONS AND PRECAUTIONS: History of hypersensitivity to any of the components of the vaccine.

APPENDIX A

Medical Conditions or Other Indications for Administration of 13-valent Pneumococcal Conjugate Vaccine (PCV13) and Indications for 23-valent Pneumococcal Polysaccharide Vaccine (PPSV23) For appropriate intervals refer to CDC. *

Underlying condition	PPSV23	PCV 13	Revaccination 5 years after first dose
• cigarette smoking • chronic heart or lung disease • diabetes mellitus • alcoholism • cirrhosis • liver disease	X		
• CSF leak • cochlear implant		X	
• sickle disease • congenital or acquired asplenia • HIV positive • congenital or acquired immunodeficiency • chronic renal failure • nephrotic syndrome • leukemia • lymphoma • Hodgkins disease • generalized malignancy • iatrogenic immunosuppression • solid organ transplant, • multiple myeloma	X	X	X

*Source: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6434a4.htm> See also <https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf>



Entire form due August 31, 2018 for Fall or January 31, 2019 for Spring to avoid \$100 processing fee.

Pre-Entrance Health Form

Table with 3 columns: Certificate of Immunization (See instructions preceding form), Department of Student Health contact info, and MR Office Use Only (Date received, Account #).

PART I

Form fields for personal information: Last Name, First Name, Middle Name, Address (Street, City, State, Zip), Date of Birth (M/D/Y), and University ID#.

PART II: TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

All information must be in English. Titer results indicating positive immunity for any required immunization are acceptable; lab results must be provided with this form.

★ Starred items are required.

★ A. MMR (MEASLES, MUMPS, RUBELLA)

Form fields for MMR: 1. Dose 1 given at age 12 months or later #1 (M/D/Y), 2. Dose 2 given at least 28 days after first dose #2 (M/D/Y).

★ B. MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135) – only required if student < 22 yrs. of age; on or after 16th birthday

Form fields for Meningococcal: 1. Quadrivalent conjugate (preferred) a. Dose #1 (M/D/Y) b. Dose #2 (M/D/Y), 2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available) Date (M/D/Y).

C. SEROGROUP B MENINGOCOCCAL – recommended for certain populations; see ACHA recommendations.

Form fields for Serogroup B Meningococcal: 1. MenB-RC (Bexsero) ___ routine ___ outbreak-related a. Dose #1 (M/D/Y) b. Dose #2 (M/D/Y), OR 2. MenB-FHbp (Trumenba) ___ routine ___ outbreak-related a. Dose #1 (M/D/Y) b. Dose #2 (M/D/Y) c. Dose #3 (M/D/Y).

★ D. TETANUS, DIPHTHERIA, PERTUSSIS – 1 dose of Tdap required on or after 10th birthday. If last Tdap is more than 10 years old, provide date of last Td or Tdap (must be within the last 10 years; after 9/1/2008 for fall or 1/1/2009 for spring).

Form fields for Tetanus/Diphtheria/Pertussis: 1. Date of last Tdap: (M/D/Y), 2. Date of last Td: (M/D/Y).

★ Part III: Tuberculosis (TB) Screening Questionnaire (to be completed by incoming students)

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? Yes No

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to <http://www.who.int/tb/country/en/>.

Have you had a previous positive TB test? Yes No

Have you had frequent or prolonged visits* to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, **CHECK** the countries or territories, above) 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

Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? Yes No

If the answer is YES to any of the above questions, The University of Virginia requires that you receive TB testing on or after 9/1/2017 (fall semester) or 1/1/2018 (spring semester). Proceed to Part IV.

If the answer to all of the above questions is NO, no further testing or further action is required.

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

I affirm that the information is accurate.

Student Signature: _____ Date: _____

Printed Student Name: _____ DOB: _____

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

>10 mm is positive:

- recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunioleal bypass and weight loss of at least 10% below ideal body weight. .

>15 mm is positive:

- persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

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

4. Chest x-ray: (Required if IGRA or TST is positive). Report in English must be attached to this form.

Date of chest x-ray: ___/___/___ Result: normal___ abnormal___
M D Y

Part V. Management of Positive TST or IGRA

All students with a positive IGRA or TST with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- Infected with HIV
- Recently infected with *M. tuberculosis* (within the past 2 years)
- History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- Have had a gastrectomy or jejunioleal bypass
- Weigh less than 90% of their ideal body weight
- Cigarette smokers and persons who abuse drugs and/or alcohol

_____ Treatment initiated.

_____ Student declines treatment at this time. Refusal of treatment for Latent Tuberculosis Infection form must be submitted with this form (page 14).

HEALTH CARE PROVIDER

Name _____ Signature _____

Address _____ Phone (_____) _____

Date: _____

Signatures/Waivers

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.

 Student/Parent 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.

 Parent/Guardian Signature Date

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: [] ; 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

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

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

(continued on next page)

Hepatitis B Vaccine Waiver

Review vaccine information before signing: http://www.immunize.org/vis/hepatitis_b.pdf

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:
http://www.immunize.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

Before submitting to Student Health, please be sure that you are not a health sciences student and:

- 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.

Submit your form via our secure patient portal: <https://www.healthyhoos.virginia.edu> (requires NetBadge account). Click on “Upload” and follow the instructions

Or 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



Student Name: _____

DOB: ___/___/___

University ID#: _____

Refusal of treatment for Latent Tuberculosis Infection

You have been identified as being infected with tuberculosis. Without treatment, about 5-10% of infected persons will develop tuberculosis disease. Some medical conditions increase the risk that latent TB infection will progress to active TB disease. Treatment for latent tuberculosis with an approved medication regimen is recommended.

I have read the information on this form about treatment of my latent TB infection. I believe I understand the potential benefit of treatment for latent TB infection and risk of progression for disease. I have had an opportunity to ask questions, which were answered to my satisfaction.

The University of Virginia Student Health Center has offered to provide me with the medication and the nursing supervision in order to decrease my risk for developing tuberculosis disease. However, I have chosen not to take the medication as recommended. If I should have a change of mind in my intention to take the medication, I understand that I can call Student Health General Medicine at 434-982-3915 to set up an appointment to discuss my treatment plan.

Reason for refusal:

Should I develop any of the following symptoms, I understand it is recommended to seek immediate medical attention:

Easy Fatigability

Cough lasting longer than 3 weeks

Night Sweats

Coughing up blood

Chills

Appetite loss

Unexpected fever

Unexplained weight loss

Chest Pain

Respiratory difficulty

Signature of the person refusing treatment

_____ **Date:** _____

Provider/Nurse _____ **Date:** _____