Welcome! The Department of Student Health and Wellness (SHW) congratulates you on your acceptance to UVA! SHW includes Counseling and Psychological Services, Medical Services, the Office of Health Promotion, and the Student Disability Access Center. Our teams are here to help you promote your well-being and to restore your health in the event of illness, injury, or a mental health concern. The SHW building is located at 550 Brandon Ave and contains a variety of laboratory services, a radiology imaging center, and a UVA Health satellite Pharmacy. The building is centered around student well-being and is home to numerous group meeting rooms, quiet study spaces, a living room with a fireplace, reflection rooms, a state-of-the-art Teaching Kitchen, and much more!

Building immunity to common communicable diseases is a critical first step in protecting your personal health and our community’s health. Completion of the pre-entrance health form (included in the following pages) allows you to demonstrate that you have met the basic immunization requirements known to promote healthy communities.

Sincerely,
Chris Holstege, M.D.
Executive Director, Department of Student Health and Wellness

RESOURCES:

- **Scheduling Visits:** After you complete and submit your pre-entrance health form, call (434) 924-5362 or visit the HealthyHoos patient portal if you’d like to schedule an appointment in our department. To learn more about the services and resources we offer, visit studenthealth.virginia.edu.

- **Connect with Local Specialists:** Care Managers can offer advice to new students who are seeking medical and mental health services beyond the scope of SHW. Care Managers can be reached in Medical Services by calling (434) 982-3915 or in Counseling and Psychological Services (CAPS) by calling (434) 243-5150.

- **Allergy Clinic:** Our Allergy Clinic can continue allergy immunotherapy injections ordered by your current allergist while you are at UVA. To learn more, visit studenthealth.virginia.edu/allergy-clinic

- **Student Disability Access Center (SDAC):** SDAC provides a wide range of individualized services and accommodations to ensure an inclusive and accessible educational experience for all students. Learn more: studenthealth.virginia.edu/sdac

IMPORTANT DUE DATES:

- **Pre-Entrance Health Form**
  - *Fall Entry:* August 1, 2022
  - *Spring Entry:* January 31, 2023
  You and your health care provider must complete and sign the pre-entrance health form. Submit your form by uploading a digital version to: studenthealth.virginia.edu/healthyhoos
  Click on “Upload” and follow the instructions.
  **Questions?** Contact Medical Records at (434) 924-1525

- **Health Insurance Coverage:**
  UVA requires all students to have health insurance. You must either submit proof of current insurance or enroll in the UVA-sponsored Aetna Student Health Plan.
  - *Fall Entry:* Enroll or submit proof from July 20, 2022 - August 31, 2022
  - *Spring Entry:* Enroll or submit proof from by January 31, 2023
  To learn more, start the enrollment process, or submit proof of insurance:
  studenthealth.virginia.edu/insurance
  **Additional questions?** Call (434) 243-2702 or email sth-ins@virginia.edu
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 who pay the comprehensive fee with their 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 20, 2022 and August 31, 2022 (Fall) in order to meet this requirement at the following address: www.uvastudentinsurance.com

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 Aetna Student Health Insurance plan.

For more information: www.studenthealth.virginia.edu/health-insurance-verification

1
Entire Form due 8/1/22 (Fall), or 1/31/23 (Spring) to avoid $100 late fee. Form must be completed in English.

Pre-Entrance Health Form: PART II

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

Tuberculosis (TB) Screening Questionnaire: Students have the option of completing Part II online.*

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, jejunooileal 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?  
If yes, which country or territory? ____________________________________________  
☐ YES  ☐ NO

Have you lived or traveled for > 3 months 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


I affirm that all of the above information is accurate.

Student/Parent Name: ____________________ Signature: ____________________ Date: ______________

*To complete online: https://www.healthyhoos.virginia.edu. Click on “forms” and select HealthyHoos TB Screening Questionnaire.
**Pre-Entrance Health Form: PART III**

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: www.studenthealth.virginia.edu/pre-entrance-health-form

### Required Vaccines

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Record Complete Dates (mm/dd/yyyy) of Vaccine Doses Given</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tdap (NOT DTaP. Dose required on/after 10th birthday.)</td>
<td>1</td>
</tr>
<tr>
<td>Tetanus Booster (Td or Tdap)</td>
<td>1 Ttetanus vaccine is required within the last 10 yrs. Td or Tdap are acceptable. Booster not required if Tdap was within the last 10 yrs.</td>
</tr>
<tr>
<td>Polio (IPV, OPV)</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (MMR) Vaccine</td>
<td>1 2</td>
</tr>
<tr>
<td>Measles (Rubeola)</td>
<td>Or date of Serologic Confirmation of Measles Immunity (must attach copy of lab result):</td>
</tr>
<tr>
<td>Rubella</td>
<td>Or date of Serologic Confirmation of Rubella Immunity (must attach copy of lab result):</td>
</tr>
<tr>
<td>Mumps</td>
<td>Or date of Serologic Confirmation of Mumps Immunity (must attach copy of lab result):</td>
</tr>
<tr>
<td>Meningococcal Vaccine (A, C, Y, W-135)</td>
<td>Please Note: Serogroup B Meningococcal Vaccine does not meet this requirement.</td>
</tr>
<tr>
<td>Hepatitis B Vaccine</td>
<td>Or date of Serologic Confirmation of Hepatitis B Immunity (must attach copy of lab result):</td>
</tr>
<tr>
<td>□ 2-dose vaccine used to complete series.</td>
<td>1 2 3</td>
</tr>
</tbody>
</table>

### Recommended Vaccines

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Record Complete Dates (mm/dd/yyyy) of Vaccine Doses Given</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A</td>
<td>1 2</td>
</tr>
<tr>
<td>Human Papillomavirus Vaccine (HPV)</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Serogroup B Meningococcal Vaccine</td>
<td>1 2 3</td>
</tr>
<tr>
<td>□ MenB-4C □ MenB-FHpb</td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td>Or date of Varicella Disease or Serologic Confirmation of Varicella Immunity (must attach copy of lab result):</td>
</tr>
<tr>
<td>COVID-19 Vaccine</td>
<td>1 Mfr:__________ 2 Mfr:__________ 3 Mfr:__________ 4 Mfr:__________</td>
</tr>
<tr>
<td>Please list dates and manufacturer for each dose on the lines provided (ex. Pfizer, Moderna, J&amp;J)</td>
<td></td>
</tr>
</tbody>
</table>

### Required Tuberculosis Screening (all students): All steps must be after 3/1/22 (Fall) or 7/1/22 (Spring)*

*The CDC recommends postponing TST and IGRA testing until ≥ 4 weeks after completion of COVID vaccine series; students will be provided with a 30-day grace period after last vaccine to submit the information below. Testing completed too early may require repeat testing.

<table>
<thead>
<tr>
<th>Screening Questionnaire Result (see page 2)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Positive (any questionnaire response of &quot;yes&quot;)</td>
<td>□ Negative (all questionnaire responses &quot;no&quot;)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tuberculosis Testing Result. Required only if TB Screening Questionnaire Positive. IGRA required for students from any country listed on page 2. IGRA preferred for all other students.</th>
<th>Result:</th>
<th>Test method:</th>
<th>Date of Test:</th>
<th>Must attach copy of result for IGRA.</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Positive □ Negative</td>
<td>□ IGRA □ PPD</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chest X-ray result. Required only if Tuberculosis Testing Positive.</th>
<th>□ Positive</th>
<th>□ Negative</th>
<th>Date of test:</th>
<th>Must attach copy of report.</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Positive □ Negative</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: _______________________________ Date: __________________

Medical Provider’s Printed Name: _______________________________ Phone: ____-____-____

Address: _______________________________