Student Name: _____ DOB: ____/____/_____ University ID #:_____

Entire Form due 8/1/23 (Fall) or 1/31/24 (Spring) to avoid $100 late fee.

Medical and Nursing 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.

Parent/ Legal Guardian 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 17, 2023 and August 31, 2023 (Fall) in order to meet this requirement at the following address: https://www.healthyhoos.virginia.edu/

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: https://www.studenthealth.virginia.edu/insurance

Student Name: _____ DOB: ____/____/_____ University ID #:_____

Entire Form due 8/1/23 (Fall) or 1/31/24 (Spring) to avoid $100 late fee.

Medical and Nursing Pre-Entrance Health Form: PART II

[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, please see UVA Health Policy HSG-008 available here: www.studenthealth.virginia.edu/pre-entrance-health-form. The information regarding the student's vaccination status including exemptions or waivers will be shared with UVA Health for the student to participate in clinical programs.

Required Vaccines	**Record Complete Dates (mm/dd/yyyy) of Vaccine Doses Given**			
Tdap (one dose required on or after 10th birthday)	1			
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			
Hepatitis B Vaccine ☐ 2-dose vaccine used to complete series.	1	2	3	
Quantitative Hepatitis B Antibody (required) Must attach copy of lab result.	Date:	Result:		
Hepatitis B Surface Antigen Only required for students with quantitative Hepatitis B Antibody < 10mIU/mL Must attach copy of lab result.	Date:	Result:		
Hepatitis B Booster Only indicated for students with quantitative Hepatitis B Antibody < 10mIU/mL and negative Hepatitis B Surface Antigen. Student may decline booster by submitting signed Hepatitis B waiver form (link above).	1			
Varicella	1	2	Or date of Serologic Confirmation of Varicella Immunity (must attach copy of lab result):	
Tetanus Booster ☐ Td ☐ Tdap ☐ Not indicated	1	**Alert: Tetanus booster is only required if the last tetanus vaccine (Td or Tdap) was more than 10 years ago.** If booster dose indicated, provide date administered and vaccine type.		
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	
COVID-19 Vaccine List dates all doses and provide manufacturer for each dose (e.g., Pfizer, Moderna, J&J)	1 Mfr:_____	2 Mfr:_____	3 Mfr:_____	4 Mfr:_____

TO BE COMPLETED BY HEALTH CARE PROVIDER:

Signature of Medical Provider/Health Department Official: _____

Medical Provider's Printed Name: _____ **Date:** _____

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

Student Name: _____ DOB: ____/____/_____ University ID #:_____

Entire Form due 8/1/23 (Fall) or 1/31/24 (Spring) to avoid $100 late fee.

Medical and Nursing Pre-Entrance Health Form: PART III

[TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER]

All students MUST complete ONE section below: A, B, or C.

Section A: Students who do not have a history of TB disease or LTBI (Latent Tuberculosis Infection)

Section B: Students who have a history of a positive TST (PPD) ≥ 10mm or a positive IGRA (Interferon Gamma Release Assay)

Section C: Students who have a history of active tuberculosis infection (TB disease)

Section A: Complete this section if no history of TB disease or LTBI (Latent Tuberculosis Infection). *The CDC recommends postponing TST and IGRA testing until ≥ 4 weeks after completion of COVID vaccine series				
Current TB Symptom Survey (required): (coughing up blood, chest pain, bad cough > 3 weeks, fever, night sweats, unexplained weight loss, weakness/ fatigue)	☐ Negative ☐ Positive			
TB Testing (required): IGRA or Two-Step TST acceptable; IGRA preferred if history of BCG vaccine. All testing must be done after the specified date: Fall entry: 3/1/2023; Spring entry: 7/1/2023.				
IGRA Date Obtained:	Result: ☐ Negative ☐ Positive	**Must attach copy of lab report.**		
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	☐ Negative ☐ Positive
Test 2:	Date placed:	Date read:	Result: _____mm	☐ Negative ☐ Positive
Chest x-ray: (required if IGRA or TST is positive) X-ray must be done after the specified date: Fall entry: 3/1/2023; Spring entry: 7/1/2023.				
Date of chest x-ray:	**Result:** ☐ Normal ☐ Abnormal	**Report must be attached to this form.**		
TB Risk Assessment (required):				
Temporary or permanent residence of ≥ 1 month in a country with a high TB rate (any country other than the US, Canada, Australia, New Zealand, and those in Northern Europe or Western Europe)	☐ Yes ☐ No			
Current or planned immunosuppression (including HIV infection, organ transplant recipient, treatment with TNF-alpha antagonist, chronic steroids, or other immunosuppressive medication)	☐ Yes ☐ No			
Close contact with someone who has had infectious TB disease since the last TB test	☐ Yes ☐ No			
Treatment for LTBI initiated? ☐ Yes ☐ No (attach medical documentation of LTBI counseling)	If treatment initiated, list medications:	Planned treatment duration: _____ months		

Section B: Complete this section if history of a positive TST (PPD) ≥ 10mm or a positive IGRA or LTBI (Latent Tuberculosis Infection)		
Date of prior positive IGRA:	☐ QFT-GIT ☐ T-Spot ☐ Other	
Date of prior positive TST:	Result: _____mm	
Date of chest x-ray (must be after the specified date: Fall 3/1/23; Spring 7/1/23):	Result: ☐ Normal ☐ Abnormal	Report must be attached to this form.
Current TB Symptom Survey: (coughing up blood, chest pain, bad cough > 3 weeks, fever, night sweats, unexplained weight loss, weakness/ fatigue)	☐ Negative ☐ Positive (attach documentation of medical evaluation including chest x-ray)	
Treated for LTBI? ☐ Yes ☐ No (attach medical documentation of LTBI counseling)	If treated, list medications:	Total duration of treatment: ___ months

Section C: Complete this section if history of active tuberculosis infection (TB disease)		
Date of Diagnosis:	Date treatment completed:	
Date of chest x-ray (must be after the specified date: Fall 3/1/23; Spring 7/1/23):	Result: ☐ Normal ☐ Abnormal	Report must be attached to this form.
Current TB Symptom Survey: (Coughing up blood, chest pain, bad cough > 3 weeks, fever, night sweats, unexplained weight loss, weakness/ fatigue)	☐ Negative ☐ Positive (attach documentation of medical evaluation including chest x-ray)	

TO BE COMPLETED BY HEALTH CARE PROVIDER:

Signature of Medical Provider/Health Department Official: _____

Medical Provider's Printed Name: _____ **Date:** _____

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