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

Entire Form due 8/1/23 (Fall), or 1/31/24 (Spring) to avoid $100 late fee. Form must be completed in English.

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 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. 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, 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	Dominica	Kiribati	Nigeria	Sudan
Bangladesh	Dominican Republic	Kyrgyzstan	Niue	Suriname
Belarus	Ecuador	Lao People's Democratic Republic	Northern Mariana Islands	Tanzania (United Republic)
Belize	El Salvador	Latvia	North Korea (Democratic People's Republic)	Tajikistan
Benin	Equatorial Guinea	Lesotho	Pakistan	Thailand
Bhutan	Eritrea	Liberia	Palau	Timor-Leste
Bolivia	Eswatini (formerly Swaziland)	Libya	Panama	Togo
Bosnia and Herzegovina	Ethiopia	Lithuania	Papua New Guinea	Tokelau
Botswana	Fiji	Madagascar	Paraguay	Tunisia
Brazil	Gabon	Malawi	Peru	Turkmenistan
Brunei Darussalam	Gambia	Malaysia	Philippines	Tuvalu
Burkina Faso	Georgia	Maldives	Qatar	Uganda
Burundi	Ghana	Mali	Republic of Moldova	Ukraine
Cabo Verde	Greenland	Malta	Romania	Uruguay
Cambodia	Guam	Marshall Islands	Russian Federation	Uzbekistan
Cameroon	Guatemala	Mauritania	Rwanda	Vanuatu
Central African Republic	Guinea	Mexico	Sao Tome and Principe	Venezuela (Bolivarian Republic of)
Chad	Guinea-Bissau	Micronesia (Federated States of)	Senegal	Viet Nam
China	Guyana	Mongolia	Sierra Leone	Yemen
China, Hong Kong SAR	Haiti	Morocco	Singapore	Zambia
China, Macao SAR		Mozambique		Zimbabwe

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.

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

Entire Form due 8/1/23 (Fall), or 1/31/24 (Spring) to avoid $100 late fee. Form must be completed in English.

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

Required Vaccines	**Record Complete Dates (mm/dd/yyyy) of Vaccine Doses Given**			
Tdap (**NOT** DTaP. Dose required on/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		**Please Note**: Serogroup B Meningococcal Vaccine does **not** meet this requirement.	
Tetanus Booster ☐ Td ☐ Tdap	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.		
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 dates and manufacturer for each dose on the lines provided (ex. Pfizer, Moderna, J&J)	1 Mfr:_____	2 Mfr:_____	3 Mfr:_____	4 Mfr:_____

Required Tuberculosis Screening (all students): All steps must be after 3/1/23 (Fall) or 7/1/23 (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.

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 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 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 Tubercolusis 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:** ____-____-_____