Dear University of Virginia Medical and Nursing students:

The Department of Student Health and Wellness congratulates you on your acceptance to UVA! Our faculty and staff are here to help you maintain your well-being and to restore your health in the event of illness, injury, or a mental health concern. Please note that remote services are available to you during periods of distance learning, such as during the novel coronavirus pandemic.

Building immunity to common communicable diseases is a critical first step in protecting your personal health and that of your patients. 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. Another important step in preparing for school is to plan for your unique health care needs.

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

RESOURCES:

- **Scheduling Visits**: To schedule your welcome visit, please call 434-982-3915 or schedule online using our secure patient portal: healthyhoos.virginia.edu
  To meet our team of providers, visit: studenthealth.virginia.edu/meet-our-team-pc

- **Connect with Local Specialists**: Care Managers can offer advice to new students who are seeking medical and mental health specialists. Care Managers can be reached in Medical Services by calling 434-982-3915 or in Counseling & 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, 2020
  - **Spring Entry**: January 31, 2021
  You and your health care provider must complete and sign the pre-entrance health form. Submit your form by uploading a digital version to our secure website: healthyhoos.virginia.edu
  (requires NetBadge account)
  Click on “Upload” and follow the instructions. Questions? Contact Medical Records: 434-924-1525

- **Health Insurance**:
  UVA requires all students to have health insurance. You must either submit proof of insurance or enroll in the UVA-sponsored Aetna student health plan.
  - **Fall Entry**: Enroll or submit proof from: July 20, 2020 - August 31, 2020
  - **Spring Entry**: Enroll or submit proof from: November 16, 2020 - February 1, 2021
  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
Entire Form due 8/1/20 (Fall), or 1/31/21 (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 ___________________________

Name or 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 for minor. 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 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 (for students 17 years and younger)

To be completed by parents or legal guardians of students who will be under the age of 18 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, 2020 and August 31, 2020 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: https://www.studenthealth.virginia.edu/health-insurance-verification

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### 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:

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

<table>
<thead>
<tr>
<th>Required Vaccines</th>
<th>Record Complete Dates (mm/dd/yyyy) of Vaccine Doses Given</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tdap (one dose required on or after 10th birthday)</td>
<td>1</td>
</tr>
<tr>
<td>Tetanus Booster (if Tdap &gt; 10 years ago)</td>
<td>1</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>1  2 Or date of Serologic Confirmation of Measles Immunity (must attach copy of lab result):</td>
</tr>
<tr>
<td>Rubella</td>
<td>1 Or date of Serologic Confirmation of Rubella Immunity (must attach copy of lab result):</td>
</tr>
<tr>
<td>Mumps</td>
<td>1  2 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) (initial or booster dose must be on or after 16th birthday) Required only for students &lt; 22 years of age.</td>
<td>1</td>
</tr>
<tr>
<td>Hepatitis B Vaccine</td>
<td>1  2  3</td>
</tr>
<tr>
<td>□ 2-dose vaccine used to complete series.</td>
<td></td>
</tr>
<tr>
<td>Quantitative Hepatitis B Antibody (required) Must attach copy of lab result.</td>
<td>Date: Result:</td>
</tr>
<tr>
<td>Hepatitis B Vaccine Booster</td>
<td>1</td>
</tr>
<tr>
<td>Only indicated for students with quantitative Hepatitis B Antibody &lt; 10mIU/mL.</td>
<td></td>
</tr>
<tr>
<td>Quantitative Hepatitis B Antibody #2</td>
<td>Date: Result:</td>
</tr>
<tr>
<td>Only indicated if Hepatitis B booster dose was given. Obtain antibody test at least 1-2 months following booster vaccine. If result &lt; 10 mIU/ml contact Student Health.</td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td>1  2 Or date of Serologic Confirmation of Varicella Immunity (must attach copy of lab result):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommended Vaccines</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 □ MenB-4C □ MenB-FHph</td>
<td>1  2  3</td>
</tr>
<tr>
<td>Other</td>
<td>1  2  3  4</td>
</tr>
<tr>
<td>Other</td>
<td>1  2  3  4</td>
</tr>
</tbody>
</table>

**HEALTH CARE PROVIDER:**

Signature of Medical Provider/Health Department Official: ___________________________ Date: ____________

Medical Provider Printed Name: ___________________________ Phone: ____-____-____

Address: _____________________________________________
Medical and Nursing Pre-Entrance Health Form: PART III

[TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER]

All students MUST have one Interferon Gamma Release Assay Test (IGRA) OR a two- or three-step Tuberculin Skin Test (TST).

IGRA- Required if patient has received BCG vaccine or was born in country of high TB incidence:

Date Obtained: QFT-GIT___ T-Spot___ 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___

Three-Step TST -- There must be no less than 7 days between first placement and first reading. The second test is placed the same day as the first reading and should be read within 48-72 hours.

Test 1: Date placed: Date read: Result: _____mm Negative___ Positive___
Test 2: Date placed: Date read: Result: _____mm Negative___ Positive___

History of a prior Positive IGRA or TST -- record results and complete TB Symptom Survey.

Date of positive IGRA: QFT-GIT___ T-Spot___ Other___
Date of positive TST: Result: _____mm

TB Symptom Survey (Check all that apply)

___None ___Coughing up blood ___Night sweats
___Cough > 3 weeks with or without sputum production ___Unexplained weight loss ___Fatigue

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 ___

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 jejunooileal 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.

HEALTH CARE PROVIDER:

Signature of Medical Provider/Health Department Official: ___________________________________________________________________ Date: ______________
Medical Provider Printed Name: ___________________________________________________________________ Phone: ______-____-
Address: _______________________________________________________________________________________

Entire Form due 8/1/20 (Fall), or 1/31/21 (Spring) to avoid $100 late fee.