Dear New University of Virginia Health Sciences 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](http://www.virginia.edu/studenthealth)  
Email: sth-mr@virginia.edu

To upload the form via our secure patient portal: [https://www.healthyhoos.virginia.edu](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](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.

1. **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 for a medical reason (TB testing is still required). For medical and nursing students, exemption may result in modification of clinical educational activities.
4. **Certificate of Immunization & Tuberculosis Testing:** To be completed at a visit by your healthcare provider. All medical and nursing students require tuberculosis testing. **All elements of tuberculosis testing must have been completed on or after 9/1/2017 (fall entry) or on or after 1/1/2018 (spring entry).**

Sincerely,

Christopher Holstege, M.D.  
Executive Director  
Department of Student Health
Requirements and Recommendations for Immunizations and TB Testing for Health Science Students

Overview of Required Vaccines

Hepatitis B: 3-dose series of hepatitis B vaccine given at 0, 1 and 6 months AND documented quantitative hepatitis B surface antibody titer consistent with immunity after the appropriate vaccine series.

Measles/Mumps/Rubella (MMR): 2 doses of MMR vaccine at least 28 days apart after 12 months of age OR 2 doses of measles and 2 doses of Mumps at least 28 days apart after 12 months of age and one dose of rubella after 12 months of age OR laboratory proof of immunity to measles/mumps/rubella.

Tetanus/Diphtheria/Pertussis: 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).

Tuberculosis Testing: The CDC recommends initial base line testing with a 2-step TB skin test or a blood test for TB infection. Subsequent annual or serial screening is determined by state regulations or risk assessment. All testing to have been done on or after 9/1/17 (fall entrance) or 1/1/18 (spring entrance).

Varicella: 2 doses of varicella vaccine given at least 4 weeks apart OR laboratory proof of immunity for those with a history of disease. If titer is negative or equivocal, give 2-dose varicella vaccine series. Do not repeat titer after series completion.

Meningococcal Quadrivalent: Required for students < 22 years of age, 1 dose required on or after 16 years of age.

Polio: Proof of primary series completion or titer indicating immunity required.

Required Immunizations

Hepatitis B:
Students must have a series of 3 hepatitis B vaccines AND a positive (≥10 mIU/mL) serological quantitative Hepatitis B surface antibody titer (anti-HBs or HBsAb) that was performed at least 1-2 months after the 3rd dose of hepatitis B vaccine. A positive titer without documentation of the 3 shot series will not be accepted.

For students with remote history of documented vaccine series completion without titer:
Draw anti-HBs titer upon matriculation
• If the anti-HBs titer is negative or equivocal, administer 1 dose of hepatitis B vaccine (#4) and re-titer at least 1-2 months after the dose.
• If the second anti-HBs titer is negative, the student will get 2 additional hepatitis B vaccines (#5 and #6) at 1 month and 6 months following dose #4. Students should pay particular attention to the date ranges in between the 3 hepatitis B vaccine doses to ensure that they are given at the appropriate time intervals for compliance.
• A final anti-HBs titer should be performed 1-2 months after the 3rd vaccine (dose #6) in the repeated hepatitis B series.
• If the student has received 2 complete series of hepatitis B vaccine (6 doses total) and does not have a positive anti-HBs titer, they are considered a “non-responder” and must be evaluated by student health personnel for further evaluation and recommendations.
• HCP who are non-responders should be considered susceptible to hepatitis B infection and should be counseled about precautions to prevent HBV infection and the need to receive hepatitis B Immunoglobulin upon exposure to hepatitis B surface antigen positive (HBsAg) blood or fluids or blood or fluids with unknown HBsAg status. Non-responders should also be tested for HBsAg to evaluate for chronic hepatitis.
B infection. HCP who are chronic hepatitis B carriers should be counseled as to local and state guidelines for the safe provision of healthcare.

For unvaccinated HCP students or those with recent history of documented vaccine completion
Administer a 3-dose series of hepatitis B vaccine at 0, 1, and 6 months AND perform anti-HBs titer 1-2 months after dose #3 to document immunity.
- If anti-HBs is greater than or equal to 10 mIU/ml, the HCP is considered immune and no further testing or vaccination is recommended
- If the anti-HBs titer is less than 10 mIU/ml, the student should receive 3 additional doses of vaccine per the usual schedule of 0, 1, and 6 months, and a repeated titer should be performed 1-2 months after dose #3.

Measles/Mumps/Rubella:
Students must meet any of the following 3 options to meet the measles, mumps, and rubella (MMR) vaccine requirement:
- 2 doses of MMR vaccine at least 28 days apart after 12 months of age.
- 2 doses of measles vaccine and 2 doses of mumps vaccine at least 28 days apart after 12 months of age and 1 dose of rubella vaccine after 12 months of age
- Laboratory proof of immunity (blood titer) to measles, mumps and rubella. If titers are negative or equivocal, the student will receive the MMR series with at least 28 days between each dose. No titer is required after the MMR vaccine series.

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

Tuberculosis Testing
Upon matriculation, health science students should undergo baseline testing for tuberculosis with either a 2-step Tuberculin Skin Test or a blood test for TB infection (Interferon Gamma Release Assay, IGRA) All testing to have been done on or after 9/1/17 (fall entrance) or 1/1/18 (spring entrance).

Tuberculin Skin Test (TST) – 2-Step
Initial repeat testing is recommended for persons with a negative TST who are to undergo periodic TST screening and who have not been tested with tuberculin recently (within 1 year). This is intended to avoid “booster phenomenon” a misclassification of a subsequently reactive TST after initial testing as a TST conversion indicating recent infection.
- The criteria for positivity is based on risk factors. HCP are at intermediate risk.
- Individuals who have received the BCG vaccine should have their results interpreted according to standard criteria.
- 2-Step TST is performed by intradermal injection of PPD (purified protein derivative) with the student returning in 48-72 hours to record induration and interpreted according to risk factors. If negative, a second TST is placed on the opposite forearm not less than 7 days nor more than 3 months after initial negative results and the results are interpreted in the standard fashion.
- If the repeat TST is positive, this is a true positive result and the student should be evaluated for latent or active TB.

IGRA
- CDC now endorses IGRA for initial screening and surveillance of HCP
- Two tests are available, Quantiferon Gold and T-spot
- Do not require a second patient visit
- Considered as sensitive as TST but more specific
- IGRA preferred to TSTs in persons who have received BCG or who are unlikely to return for a test reading
Varicella:
Students must have either 1 of the following 2 options to meet the varicella vaccine requirement:
- 2 documented varicella vaccines that were given at least 4 weeks apart.
- Laboratory proof of immunity (blood titer) to varicella. If the varicella titer is negative or equivocal, the student should receive the varicella series with the doses at least 4 weeks apart. No titer is required after the varicella vaccine series.

An affidavit or documentation of the student having had varicella disease (i.e., chicken pox or shingles) will not be accepted for any Health Sciences Student.

Meningoccal Quadrivalent (A, C, Y, W-135): Required for students < 22 years of age.
- 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.

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.

Recommended Vaccinations

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

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.
### Pre-Entrance Health Form – Health Science Students

**Certificate of Immunization**  
*(See instructions preceding form)*

<table>
<thead>
<tr>
<th>Department of Student Health</th>
<th>University of Virginia</th>
<th>MR Office Use Only:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P.O. Box 800760</td>
<td>Date received:</td>
</tr>
<tr>
<td></td>
<td>Charlottesville, Virginia 22908-0760</td>
<td>____________________</td>
</tr>
<tr>
<td></td>
<td>Phone: (434) 924-1525, FAX: (434) 982-4262</td>
<td>Account #: ____________</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:sth-mr@virginia.edu">sth-mr@virginia.edu</a></td>
<td></td>
</tr>
</tbody>
</table>

### PART I

| Last Name | ____________________________ | | | Middle Name | ____________________________ |
|-----------|-----------------------------| | | | ____________________________ |

<table>
<thead>
<tr>
<th>Address</th>
<th>____________________________</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>University ID#</th>
<th>____________________________</th>
</tr>
</thead>
</table>

| Date of Birth | ____________________________ | | | | | | |
|---------------|-----------------------------| | | | | | |

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

**Starred items are required. All information must be in English.**

#### 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).

| Tdap | Mo./day/year | | |
|------|--------------| | |
| Td   | Mo./day/year | | |

#### Measles/Mumps/Rubella: 2 doses of MMR at least 28 days apart after 12 months of age OR 2 doses of Measles and 2 doses of Mumps at least 28 days apart after 12 months of age and 1 dose of Rubella after 12 months of age OR laboratory proof of immunity (blood titer) to measles/mumps/rubella. If titers are negative or equivocal, administer MMR series with doses at least 28 days apart. No titer is required after series completion.

| MMR - 2 required on or after 1st birthday | (#1) Mo./day/year | (#2) Mo./day/year | | |
|------------------------------------------|-------------------|-------------------| | |

**OR**

| Measles | 2 required on or after first birthday | (#1) Mo./day/year | (#2) Mo./day/year | | |
|---------|---------------------------------------|-------------------|-------------------| | |
| Mumps   | 2 required on or after first birthday  | (#1) Mo./day/year | (#2) Mo./day/year | | |
| Rubella | 1 required on or after first birthday  | (#1) Mo./day/year | | |

**OR**

| Measles Titer | | Date of Titer | Result | |
|---------------| | | | |
| Mumps Titer   | | | | |
| Rubella Titer | | | | |
| *must attach laboratory results* | | | | |

#### Varicella: 2 doses of Varicella at least 4 weeks apart OR laboratory proof of immunity to varicella. If titer is negative or equivocal, administer Varicella series with doses at least 4 weeks apart. No titer is required after series.

| Varicella | 2 doses | (#1) Mo./day/year | (#2) Mo./day/year | | |
|-----------|---------|-------------------|-------------------| | |

**OR**

| Varicella Titer | | Date of Titer | Result | |
|-----------------| | | | |
| *must attach laboratory results* | | | | |
**Hepatitis B:** 3 doses of hepatitis B vaccines and a positive (≥10 mIU/mL) serological quantitative hepatitis B surface antibody titer (HBsAb) 1-2 months after the date of the last vaccine is considered proof of lifelong immunity. If series was completed in the remote past, and if the titer checked upon matriculation is negative, student will get 1 hepatitis B vaccine dose (#4) and re-titer at least 1-2 months after vaccine. If the second titer is negative, student will get 2 additional hepatitis B vaccines (#5 and #6) per the standard schedule. A final titer should be done 1-2 months after the 6th vaccine and if this is negative, the student should be considered a non-responder and evaluated and counseled appropriately. Those students recently vaccinated with a negative titer after the 3rd dose can receive a second series with a re-titer 1-2 months after the 6th dose. Non-responders should be counseled and evaluated appropriately at Student Health.

<table>
<thead>
<tr>
<th>Hepatitis B Series</th>
<th>(#1) mo./day/year</th>
<th>(#2) mo./day/year</th>
<th>(#3) mo./day/year</th>
</tr>
</thead>
</table>

**Hepatitis B Quantitative Titer**

*must attach laboratory results*

<table>
<thead>
<tr>
<th>Date of Titer</th>
<th>Result</th>
</tr>
</thead>
</table>

**Hepatitis B Series Repeat**

<table>
<thead>
<tr>
<th>(#1) mo./day/year</th>
<th>(#2) mo./day/year</th>
<th>(#3) mo./day/year</th>
</tr>
</thead>
</table>

**Hepatitis B Quantitative Titer Repeat**

*must attach laboratory results*

<table>
<thead>
<tr>
<th>Date of Titer</th>
<th>Result</th>
</tr>
</thead>
</table>

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

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).
   a. Dose #1 ____/____/_______  b. Dose #2 ____/____/_______
   M D Y M D Y

2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available). Date ____/____/_______
   M D Y

**B. SEROGRUP B MENINGOCOCCAL – recommended for certain populations; see ACHA recommendations.**

1. MenB-RC (Bexsero) ___ routine ___ outbreak-related
   a. Dose #1 ____/____/_______  b. Dose #2 ____/____/_______
   M D Y M D Y

   OR

2. MenB-FHbp (Trumenba) ___ routine ___ outbreak-related
   a. Dose #1 ____/____/_______  b. Dose #2 ____/____/_______  c. Dose #3 ____/____/_______
   M D Y M D Y

**C. HEPATITIS A**

1. Immunization (hepatitis A)
   a. Dose #1 ____/____/_______  b. Dose #2 ____/____/_______
   M D Y M D Y

2. Immunization (Combined hepatitis A and B vaccine)
   a. Dose #1 ____/____/_______  b. Dose #2 ____/____/_______  c. Dose #3 ____/____/_______
   M D Y M D Y

**D. HUMAN PAPILLOMAVIRUS VACCINE**

Immunization (indicate which preparation, if known)  Quadrivalent (HPV4) _____  or  Bivalent (HPV2) _____  or  9-valent (HPV9) _____

a. Dose #1 ____/____/_______  b. Dose #2 ____/____/_______  c. Dose #3 ____/____/_______
   M D Y M D Y

**E. PNEUMOCOCCAL POLYSACCHARIDE VACCINE**

PCV 13 _____  Date ____/____/_______  PPSV 23 _____  Date ____/____/_______
   M D Y M D Y
F. POLIO

1. OPV alone (oral Sabin three doses):
   #1 M D Y #2 M D Y #3 M D Y

2. IPV/OPV sequential:
   IPV #1 M D Y IPV #2 M D Y OPV #3 M D Y OPV #4 M D Y

3. IPV alone (injected Salk four doses):
   #1 M D Y #2 M D Y #3 M D Y #4 M D Y

G. ADDITIONAL IMMUNIZATIONS

Immunization: _______________________________ Date: ___/___/___
                          M   D   Y
Immunization: _______________________________ Date: ___/___/___
                          M   D   Y
Immunization: _______________________________ Date: ___/___/___
                          M   D   Y

HEALTH CARE PROVIDER

Name _______________________________ Signature _______________________________
Address _______________________________ Phone (__________) _______________________
Date: _______________________________
TUBERCULOSIS TESTING
HEALTH SCIENCE STUDENTS

Name: ___________________________ DOB: ______________ University ID #: ______________

Students MUST have one Interferon Gamma Release Assay Test (IGRA) (must attach lab results) OR a two- or three-step Tuberculin Skin Test (TST). All testing and X-rays must be done during time frames prior to semester start:

Fall start: on or after September 1, 2017 | Spring start: on or after January 1, 2018

1. IGRA (Required if patient has received BCG vaccine or was born in country of high TB incidence)
   Date Obtained: __/__/____ (specify method) QFT-GIT_TSpot
   M D Y
   Result: negative__ positive___

   IGRA = Quantiferon Gold or T-Spot. Indeterminate or borderline results are not acceptable. Repeat test or administer TST.

2. 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 □ Positive □ Negative
   Test 2: Date placed:_______ Date read:_______ Result:______ mm □ Positive □ Negative

   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 □ Positive □ Negative
   Test 2: Date placed:_______ Date read:_______ Result:______ mm □ Positive □ Negative

**Interpretation guidelines

>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 jejunoileal 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.
3. **History of a prior Positive IGRA or TST – record results and complete TB Symptom Survey.**
   
   Date of positive IGRA: ______ (specify method)  QFT-GIT ___  T-Spot ___  other___
   
   OR
   
   Date of positive TST: ________ Result: ______ mm
   
   AND
   
   TB Symptom Survey (Check all that apply)
   
   □ None  □ Cough>3 weeks with or without sputum production  □ Coughing up blood
   
   □ Unexplained fever □ Poor appetite □ Unexplained weight loss □ Night sweats □ Fatigue

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____

5. **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 jejunoileal 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 13).

**HEALTH CARE PROVIDER**

Name __________________________________________ Signature __________________________________________

Address __________________________________________ Phone (__________) __________________________

Date: _________________________________
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)
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:
- A health care provider has completed and signed the Immunization Record.
- 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
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:

<table>
<thead>
<tr>
<th>Easy Fatigability</th>
<th>Appetite loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cough lasting longer than 3 weeks</td>
<td>Unexpected fever</td>
</tr>
<tr>
<td>Night Sweats</td>
<td>Unexplained weight loss</td>
</tr>
<tr>
<td>Coughing up blood</td>
<td>Chest Pain</td>
</tr>
<tr>
<td>Chills</td>
<td>Respiratory difficulty</td>
</tr>
</tbody>
</table>

Signature of the person refusing treatment

__________________________________________________________ Date: ________

Provider/Nurse __________________________________________ Date: ________