



## Tuberculosis Screening Form

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ L#: \_\_\_\_\_

The Centers for Disease Control and the U.S. Public Health Service recommend that tuberculosis testing be performed on ALL individuals who may be at increased risk of tuberculosis disease. For more information, visit <http://www.acha.org> or refer to the CDC's Core Curriculum on Tuberculosis available at <http://www.cdc.gov/nchstp/tb/pubs/corecurr/>.

1. Have you had a prior positive TB test? (If yes, you **must** complete symptom survey.)  yes  no
2. Have you ever been a close contact with persons known or suspected to have active TB disease  yes  no
3. Have you been a resident and/or employee in high risk settings such as long-term care facilities, homeless shelters, correctional facilities, or any other health care facilities?  yes  no
4. Have you been a healthcare worker or volunteer serving high risk clients (such as the homeless, prison settings or hospitals)?  yes  no
5. Have you ever injected illegal drugs?  yes  no
6. Do you have signs or symptoms of active TB disease: unexplained fever, weight loss, loss of appetite, night sweats, persistent cough for more than 3 weeks, and/or cough with production of bloody sputum?  yes  no
7. Do you have a clinical condition such as HIV, diabetes, cancer, kidney disease, silicosis, leukemia or lymphoma, chronic malabsorption syndromes, removal of part of your stomach or have been on prolonged corticosteroid or immunosuppressive therapy?  yes  no
8. Were you born in a country listed below and lived there for three (3) months or more?  yes  no
9. Have you lived in or visited any country listed below for three (3) months or more?  yes  no

I have answered "YES" to 1 or more of the above questions. A TB test is required. Submit results of a TB test or IGRA done in the United States within the past year.

I have answered "NO" to ALL of the above questions. No TB test is required.

Signature of Student or Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Afghanistan, Algeria, Angola, Argentina, Armenia, Azerbaijan, Bangladesh, Belarus, Belize, Benin, Bhutan, Bolivia, Bosnia and Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Burundi, Burma, Cabo Verde, Cambodia, Cameroon, Central African Republic, Chad, China, Colombia, Congo, Cote d'Ivoire, Djibouti, Dominican Republic, Ecuador, El Salvador, Equatorial Guinea, Eritrea, Ethiopia, Fiji, French Polynesia, Gabon, Gambia, Georgia, Ghana, Guam, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iran, Iraq, Kazakhstan, Kenya, Kiribati, Kuwait, Kyrgyzstan, Korea, Laos, Latvia, Lesotho, Liberia, Lithuania, Libya, Madagascar, Malawi, Malaysia, Maldives, Mali, Marshall Islands, Mauritania, Mexico, Micronesia, Moldova, Mongolia, Morocco, Mozambique, Myanmar, Nauru, Nepal, Nicaragua, Niger, Nigeria, Northern Mariana Islands, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Portugal, Qatar, Romania, Russian Federation, Rwanda, Sao Tome and Principe, Senegal, Serbia, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, Sudan, Suriname, Swaziland, Syrian Arab Republic, Tajikistan, Thailand, Timor-Leste, Togo, Tunisia, Turkmenistan, Tuvalu, Tanzania, Uganda, Ukraine, Uruguay, Uzbekistan, Vanuatu, Venezuela, Viet Nam, Wallis and Futuna Islands, Yemen, Zambia, Zimbabwe



## Certificate of Immunization

All full-time students are required by the Code of Virginia (Section 23-7.5) to provide documentation of their immunizations by a licensed health professional. If you are unable to provide appropriate documentation, vaccines may be repeated. A registration hold for the upcoming semester will be placed if all required immunizations are not up-to-date.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Born in the USA?  Yes  No If no, country of birth: \_\_\_\_\_

Student L# \_\_\_\_\_ Email: \_\_\_\_\_ Cell# \_\_\_\_\_

### To be completed and signed by a licensed health-care provider

Any attached documents in a language other than English must be translated into English by the health care provider

Ⓡ	<b>= REQUIRED</b>			
Ⓡ	<b>Tuberculosis Screening</b>	All students regardless of enrollment status are required to complete the tuberculosis screening form		
<b>IMMUNIZATIONS</b>				
	<b>Diphtheria, Pertussis, Tetanus (DPT)</b>	Student has received _____ doses. Last dose given on _____.		
	<b>Hepatitis A</b>	① _____	② _____	
Ⓡ	<b>Hepatitis B</b> Or <b>Hep A/B</b>	① _____	② _____	③ _____ OR Serological confirmation of immunity. Attach copy of lab result. OR Waiver signed.
	<b>HPV</b>	① _____	② _____	③ _____ HPV4 <input type="checkbox"/> HPV9 <input type="checkbox"/>
Ⓡ	<b>Meningococcal Vaccine</b>	① _____	*One-Two doses, last dose required after 16 <sup>th</sup> birthday OR Waiver Signed MCV4 <input type="checkbox"/> MPS4 <input type="checkbox"/>	
	<b>Meningococcal Group B</b>	① _____	② _____	③ _____ <input type="checkbox"/> Bexsero <input type="checkbox"/> Trumenba
Ⓡ	<b>Measles, Mumps, Rubella (MMR)</b>	① _____ After first birthday	② _____ 28 Days after 1 <sup>st</sup> Dose	OR serological confirmation of immunity to measles, mumps, and rubella. Attach copy of lab result.
Ⓡ	<b>Polio (IPV or OPV)</b>	① _____	② _____	③ _____
	*Primary series, doses at least 28 days apart with last dose after age 4 years *Required for 18 and under OR from countries of high risk including Afghanistan and Pakistan			
Ⓡ	<b>Tetanus, diphtheria, pertussis (Tdap)</b>	Required within 10 years _____		OR Tetanus, diphtheria (Td) within 10 years _____
	<b>Varicella (Chicken Pox)</b>	① _____	② _____	OR Date of Disease _____
Health Care Provider or Health Department Signature		Date		Phone



## Waiver Information for Meningococcal Disease & Hepatitis B

Please read the following information on Meningococcal Disease and Hepatitis B before signing the waiver on the Certification of Immunization.

### Hepatitis B

Hepatitis B is a potentially fatal disease that attacks the liver. The virus can cause short-term (acute) illness that leads to loss of appetite, tiredness, diarrhea and vomiting, jaundice (yellow skin or eyes) and pain in muscles, joints and stomach. Many people have no symptoms with the illness. It can also cause long-term (chronic illness that leads to liver damage, liver cancer, and death.

According to the Centers for Disease Control, about 800,000-1.4 million people in the U.S. have chronic Hepatitis B infection. Each year approximately 40,000 people, mostly young adults, become infected with Hepatitis B virus. Young adults are more likely to contract Hepatitis B infection due to greater likelihood of high-risk behaviors such as multiple sexual partners.

Approximately 3,000 people die from chronic Hepatitis B infection annually. It is spread through contact with blood and body fluids of an infected person, such as having unprotected sex with an infected person or sharing needles when injecting illegal drugs. Unvaccinated health-science students are at risk of contracting Hepatitis B through an accidental occupational needle stick exposure.

There are several ways to prevent Hepatitis B infections including avoiding risky behavior, screening pregnant women and vaccination. Vaccine is the best prevention. The vaccine series typically consists of three injections given over a six month period, which are available through your private health care provider or Local Health Department.

### Meningococcal Disease

Meningococcal disease is the leading cause of bacterial meningitis in children 2-18 years old in the U.S. Meningitis is an infection of the brain and spinal cord coverings. Meningococcal disease can also cause blood infections. According to the Centers for Disease Control, about 2,600 people get meningococcal disease each year in the U.S. Of these cases, 10-15% die and of those who live, another 10% may require limb amputation, develop kidney failure or brain damage, become deaf, and suffer seizures or strokes.

College freshmen, particularly those who live in dormitories, have a slightly increased risk of getting meningococcal disease as illustrated by a case rate of 1.4/100,000 18-23 years old as opposed to a case rate of 1.4/1,000,000 18-23 year olds in the general population.

Meningococcal vaccine is effective in preventing four types of meningococcal disease including two of the three most commonly occurring types in the U.S. The vaccine is 85-100% effective in preventing serotype A and C in older children and adults. It does not however protect against serotype B which causes one third of cases in patients 15-24 years. Therefore, in the event of an outbreak, even previously immunized individuals should contact their health care providers.

ACIP recommends routine vaccination of persons with meningococcal conjugate at age 11 or 12 years with a booster dose at age 16. **Persons who receive their first meningococcal conjugate vaccine at or after 16 years do not need a booster dose.** Routine vaccination of healthy persons 21 years or older who are not at increased risk of exposure to N. Meningitidis is not recommended.

The vaccine is available at a Local Health Dept. or physician.



Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Student L #: \_\_\_\_\_

### Meningococcal Vaccine Waiver

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

### Religious Exemption

Any student who objects on the grounds that administration of immunizing agents conflicts with his or her religious tenets or practices shall be exempt from the immunization requirements unless an emergency or epidemic of disease has been declared by the Board of Health. A notarized certificate from your state health department must be attached.

### Hepatitis B Vaccine Waiver

I have read and reviewed information on the risk associated with hepatitis B disease, availability and effectiveness of any vaccine against hepatitis B disease and I choose not to be vaccinated against hepatitis B disease.

\_\_\_\_\_  
Signature of Student or Parent/Legal Guardian      Date

### Medical Exemption

As specified in the Code of Virginia 22.1-27.2, C (ii), 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;HIB;Pneum;Measles;Rubella;Mumps;HBV;Varicella;Meningococcal. This contraindication is permanent ( ) or temporary ( ) and expected to preclude immunizations until:

Date (Mo/Day/Yr): \_\_\_\_\_

Medical Provider Signature: \_\_\_\_\_