Office of the Vice Provost for Health

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Health and Immunization Form

Part I. Student Demographic and Emergency Contact Information

Name: _____
Last *First* *D.O.B*

Address: _____
Street *City/State* *Zip Code*

Phone: ( ) _____ Student G#: _____

Emergency Contact: _____Relationship: _____

Address: _____
Street *City/State* *Zip Code*

Phone: ( ) _____

Part II. Immunization Documentation - Month/Day/Year

MMR (Measles, Mumps, Rubella):

Immunization dates: #1 ___/___/____: Immunization date #2___/___/____

NOTE: <u>If less than 2 immunization dates – titer results must be submitted</u>

Td or Tdap (Tetanus and Diphtheria or Tetanus, Diphtheria and Acellular Pertussis):

Td:___/___/____ or Tdap:___/___/____ Within the last 10 years

- **Must include date of last Tdap after age 11:___/___/____**

Hepatitis B immunizations dates (series of 3 immunizations) AND Hepatitis B surface antibody titer result:

Immunization dates: #1___/___/____ #2___/___/____ #3___/___/____ **AND**

Date Hepatitis B surface antibody titer drawn:___/___/____ **<u>Lab result MUST be submitted</u>**

Dates of additional immunizations: #1___/___/____ #2___/___/____ #3___/___/____

Varicella:

Varicella immunization dates: #1___/___/____ #2___/___/____ **OR** Date of Varicella disease:___/___/____

NOTE: If less than 2 immunization dates or documentation of disease - titer result must be submitted

Influenza:

Date of last influenza immunization: ____/____/____

Meningococcal: <u>Required for Medical Laboratory Science Program only:</u>

Meningococcal immunization within the last 5 years: ___/___/____

Part III. Tuberculosis (TB) Screening, Two-step Skin Test or Quantiferon Gold/T-Spot Test

A two-step TB skin test or Quantiferon-Gold/T-Spot test is required, unless history of a positive tuberculin test. The first TB skin test must be documented as "negative" and that it was completed within the past 12 months, the second TB skin test must be completed no earlier than 7 days after the first.

TB skin test #1 Date placed:___/___/____ Date read:___/___/____ Result: _____mm Read by: _____
TB skin test #2 Date placed:___/___/____ Date read:___/___/____ Result: _____mm Read by: _____

OR Quantiferon-Gold/T-Spot test (used instead of the two skin tests)
Date of test:___/___/____ **Lab result must be submitted**

OR if positive TB test **OR** individual with history of a positive TB test:
Date of baseline chest x-ray: ___/___/____ X-ray results: _____ **X-ray report must be submitted**

Date of TB symptom review: ___/___/____ Is individual free of signs and symptoms of TB? _____

Part IV. Review of Essential Functions and Technical Standards (See Attachment)

Only required for the following programs of study: Athletic Training, Nursing, Medical Laboratory Science, Occupational Therapy, Physical Therapy and Physician Assistant.

Part V. Physical Exam and Verification

I have obtained a health and social history, performed a physical exam, and have reviewed the program essential functions and/or technical standards (if required for this individual's program).
Please initial your response: ____Yes ____No

In my opinion this individual is mentally and physically capable of full participation in their designated program.
Please initial your response: _____Yes_____No

If this individual is NOT capable to fully participate please comment on limitations: _____
_____
_____

Part VI. Healthcare Provider Information

Health Care Provider: _____ Office: _____
(Please Print)
Signature: _____Date: _____/_____/_____

Address: _____
Street *City/State* *Zip Code*

Phone: ( ) _____

Student Name: _____ D.O.B ___/___/____ G #_____