VirginiaTech
Division of Student Affairs

Schiffert Health Center (0140)
895 Washington Street, SW
Blacksburg, Virginia 24061
540/231-6444 Fax: 540/231-6900 or 540/231-7473
E-mail: health@vt.edu
www.healthcenter.vt.edu

Accredited by the Accreditation Association for Ambulatory Health Care, Inc.

Dear Virginia Tech Student:

Congratulations on your acceptance and decision to attend Virginia Tech. We at the Schiffert Health Center look forward to serving your health needs to ensure your academic success. To help us do so, we need information about your health status. Please complete and submit the following items to Schiffert Health Center **AT LEAST ONE MONTH** before your planned arrival at Virginia Tech. The forms may be mailed or delivered to the address listed below.

- **IMMUNIZATION HISTORY FORM:** Carefully read the list of required immunizations to be sure that you have complied fully with state and university requirements. **You may upload information electronically a**t https://osh.healthcenter.vt.edu however, a signed form must be submitted per Commonwealth of Virginia Law (Code of Virginia, Section 23-7.5) which requires that all full-time students (undergraduate, graduate, and transfer) submit an immunization history that has been signed by a healthcare provider and documents all required immunizations.

- **TUBERCULOSIS RISK ASSESSMENT FORM:** Complete all questions. If you answered "Yes" to any questions, a PPD Test, QuantiFERON Tb Gold Test or chest x-ray may be required.

- **TUBERCULOSIS SKIN TESTING FORM:** Complete **ONLY** if a TB Test is required.

- **MEDICAL HISTORY:** Complete and submit this electronically at https://osh.healthcenter.vt.edu
  ****** PLEASE MAKE SURE TO ENABLE POP-UPS. ******

FAILURE TO RECEIVE ALL REQUIRED IMMUNIZATIONS AND TO PROVIDE THE UNIVERSITY WITH DOCUMENTATION WILL BLOCK YOU FROM REGISTERING FOR CLASSES FOR YOUR SECOND SEMESTER. AMONG OTHER DIFFICULTIES THAT THIS WILL CAUSE, YOU WILL BE PREVENTED FROM GETTING FIRST CHOICE OF CLASSES DURING REGISTRATION AND IF NOT CLEARED BY THE START OF THE SEMESTER PREVENTED FROM ATTENDING CLASSES.

Medical Records Department
Schiffert Health Center (0140)
McComas Hall – Virginia Tech
895 Washington Street, SW
Blacksburg, VA 24061

Exemptions: Students are exempt from the immunization requirements if a medical contraindication or religious belief prohibits immunization. A signed statement from a health care provider is required for a medical exemption. Those born before 1957 are also exempt from the requirements for Measles, Mumps and Rubella (MMR) vaccines.

Details of the required immunizations are given in the attached *Instructions for Completing the Immunization History Form*.

If you have questions about these requirements or about completing the enclosed Schiffert Health Center form, please contact our Medical Records Department at (540) 231-8104.

Sincerely,

Kanitta Charoensiri, D.O., M.B.A.
Director, Schiffert Health Center

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IMMUNIZATION HISTORY FORM
Schiffert Health Center

Name (Last, First, Middle) _____

VT ID#: _____ Birth date: _____ Cell Phone#: _____ Email: _____

Virginia Tech Entry Date: _____ Undergraduate: ☐ Graduate: ☐ Male: ☐ Female: ☐

REQUIRED

REQUIRED IMMUNIZATIONS	REQUIREMENT (MM/DD/YYYY)	REQUIRED FOR
MMR (Measles, Mumps, Rubella) **OR** • Measles **AND** • Mumps **AND** • Rubella (German Measles)	2 Doses #1 _____ #2 _____ **OR** 2 Doses: #1 _____ #2 _____ Or Titer _____ **AND** 2 Doses: #1 _____ #2 _____ Or Titer _____ **AND** 1 Dose: #1 _____ Or Titer _____	• Students born in 1957 or later MMR: • 1st dose due at 12 months of age or older • 2nd dose due at least one month later Individual Measles, Mumps: • 1st dose due at 12 months of age or older • 2nd dose due at least one month later Individual Rubella: • Single dose due at 12 months of age or older • Attach titer results with lab values if done
Polio	Doses: #1_____ #2_____ #3_____ #4_____	• All students should have the series competed at 4 years of age or older
Tetanus and Diphtheria (Td or Tdap)	Td _____ Tdap _____	• All students must have one dose within the past 9 years
Hepatitis B	Doses: #1 _____ #2 _____ #3 _____	• All students unless waiver signed
Meningococcal	Dose: #1 _____	• All students must have one vaccine within the past 4 years unless waiver signed

WAIVERS – Signature Required

Meningococcal Vaccine: I have been informed of the risks and health hazards of meningococcal infection as well as the benefits of the vaccine. I choose not to be immunized. _____(Parent/legal guardian if under age 18)**Date**:_____

Hepatitis B Vaccine: I have been informed of the risks and health hazards of hepatitis B infection as well as the benefits of the vaccine. I choose not to be immunized. _____ (Parent/legal guardian if under age 18)**Date:**_____

HEALTH CARE PROVIDER SIGNATURE

I have reviewed the immunization records of this patient and certify that the entries above are correct.

Name: _____ Date: _____ Phone: _____

Office Address: _____

Signature: _____

SHC OFFICE USE: PPD/QFTG_____ MMR _____ Men _____ Td/Tdap_____ Hep B _____ POLIO_____ Email Sent:_____

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SCHIFFERT HEALTH CENTER
TUBERCULOSIS RISK ASSESSMENT FORM (REQUIRED)

Date: _____ **VT ID#:** _____ **Birth Date:** _____ **Email:** _____

Name (Last, First, Middle) _____

Address _____ **City:** _____ **State:** _____

Zip Code: _____ **Country of Origin:** _____

HISTORY RISK:

1. Have you ever had a positive TB skin test? ☐ **No** ☐ **Yes** **Date of Positive PPD:** _____ **mm Induration** _____
2. Have you had a QuantiFERON Tb Gold Test? ☐ **No** ☐ **Yes** **Date:** _____ **Result:** ☐ **Positive** ☐ **Negative**
3. Have you had a T-SPOT Tb Test? ☐ **No** ☐ **Yes** **Date:** _____ **Result:** ☐ **Positive** ☐ **Negative**

CHECK THE BOX IF ANY OF THE FOLLOWING APPLY: ***A PPD or QFT-G is required if any section is checked.***

CURRENT SYMPTOMS: **Do you currently have any of the following symptoms?** ☐ **NO** **If YES, check all that apply.**

Persistent cough for more than 3 weeks	☐ **Yes**	Persistent night sweats	☐ **Yes**	Loss of appetite	☐ **Yes**
Fever or chills	☐ **Yes**	Unexplained weight loss	☐ **Yes**	Productive cough with bloody sputum	☐ **Yes**

EXPOSURE RISKS: **If yes to any question, a TB skin test and completed Tuberculosis Skin Testing Form is required.**

1. **Have you within the last 2 years, worked or volunteered (>8 hr/week) in the following types of facilities?** ☐ **NO** ☐ **YES**

Homeless Shelter	Long-term Care	Residential Facilities for patients with AIDS	Rehab Facility	Prisons	Hospitals, Nursing Homes

2. **Have you recently come into contact with a person who has Tuberculosis?** ☐ **NO** ☐ **YES**
3. **Have you ever used any illegal injected drugs?** ☐ **NO** ☐ **YES**

HEALTH RISKS: **Do you currently have any of the following conditions?** ☐ **NO** **If YES, check all that apply.**

Leukemia, lymphoma; Cancers of head or neck; Underweight or malnourished	☐ **Yes**	Gastrectomy, jejunoileal bypass, chronic malabsorptive conditions	☐ **Yes**	Solid organ transplant (kidney, heart); On dialysis or chronic renal failure	☐ **Yes**
Silicosis, Diabetes, HIV Infection Chemotherapy	☐ **Yes**	Prolonged corticosteroid therapy or other immunosuppressive disorders	☐ **Yes**	On any TNF antagonist medication (Humira, Embrel or Remicade for RA or Crohn's Disease	☐ **Yes**

TRAVEL RISKS: **Have you lived or traveled to any country in the following areas of the world for a duration of three (3) months or more within the past five (5) years?** ☐ **NO** **If YES, check all that apply.**

☐ India and other Indian Subcontinent nations	☐ Central America, including Mexico	☐ South Pacific (except Australia, New Zealand)	☐ Middle East (except Egypt, Saudi Arabia, Jordan, Lebanon, UAE)	☐ Cuba, Haiti, Dominican Republic
☐ Asia	☐ Africa	☐ Eastern Europe	☐ South America	☐ Portugal

SUBMIT THIS FORM WITH THE IMMUNIZATION HISTORY FORM.

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SCHIFFERT HEALTH CENTER
TUBERCULOSIS SKIN TESTING FORM

Date: _____ VT ID#: _____Birth Date: _____Email: _____

Name (Last, First, Middle) _____

TUBERCULIN SKIN TEST:

Date placed: _____ L☐ R☐ Date read: _____ (must be within 48 to 72 hours)

Placed By: _____ Read By: _____

Lot #: _____ Exp Date: _____ Result _____ mm (record actual mm of induration, transverse diameter. If no induration, record as "0" mm)

FINAL INTERPRETATION – Based on Criteria below. ☐ **POSITIVE** ☐ **NEGATIVE**

☐ **Reaction ≥ 5 mm of Induration**	☐ **Reaction ≥ 10 mm Induration**	☐ **Reaction ≥ 15 mm Induration**
HIV positive persons	Recent immigrants to US(within last 5 years) from high prevalence countries	Persons with no risk factors for TB
Organ transplant patients; other immunosuppressed patients (receiving ≥ 15 mg/d of prednisone for 1 month or more	Persons with silicosis, DM, chronic renal failure, leukemias/lymphomas, CA of head, neck, and lung, weight loss of ≥ 10% of ideal body weight, gastrectomy	Persons who are otherwise at low risk and are tested at the start of employment, a reaction of ≥ 15 mm is considered positive
Changes on x-ray consistent with prior TB	IV drug users	
Recent contacts of infectious TB case	Mycobacterial laboratory personnel	
	Children < 5 years of age; or infants, children or adolescents exposed to high-risk adults	
	Residents/employees of high-risk congregate settings	
	Recent conversion (increase of ≥ 10 mm of induration within the past 2 years	

CHEST X-RAY: Required with positive PPD or QFT-G test, unless documentation of treatment provided and asymptomatic. If history of previous positive PPD or QFT-G test, chest x-ray must be completed within **six months** prior to arrival at Virginia Tech.

Date of chest x-ray: _____ Date of Positive PPD: _____

RESULT: ☐ **NORMAL** ☐ **ABNORMAL**

TREATMENT FOR LATENT TB:

Has the student received Anti-Tubercular Medication? ☐ YES ☐ NO

If YES, INH given? ☐ YES ☐ NO Other treatment:

_____

Duration of Treatment: From _____ to _____

CERTIFICATION OF HEALTHCARE PROVIDER

Name: _____ Date: _____ Phone: _____

Signature: _____