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

Dear New 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 **BY December 31, 2022**.

Your health care provider must complete and sign this form. The form may be submitted by mail, fax, electronic upload or dropped off at Schiffert Health Center:

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

Please ensure you have completed all **required** sections listed below prior to submission. Schiffert Health Center offers a secure website **https://osh.healthcenter.vt.edu/** where you may upload and 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. **Schiffert Health Center will accept a copy of your immunizations from your practitioner's office.**

**Please note the following requirements:**

1. **Designated Emergency Contact(s):** May be your parent, guardian, spouse, or next-of-kin who could be of support to you, or assist with medical decision making in the event you are unable to speak for yourself.
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 campus.
3. **Exemptions to Immunizations**: On occasion, a student may elect to opt out of vaccine requirements based on their religious beliefs or medical reasons (TB testing is still required). The Medical Exemption can be found on page 1 of 4 of this packet. Please refer to our website **www.healthcenter.vt.edu** for a copy of the religious exemption form and directions for completion.
4. **Medical Conditions:** Complete and submit the online medical history at **https://osh.healthcenter.vt.edu**
5. **Certificate of Immunization & Tuberculosis Screening/Testing:** These must be completed by your healthcare provider. All students are required to have the tuberculosis screening completed.

Sincerely,

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

STUDENT AFFAIRS
SCHIFFERT HEALTH CENTER
VIRGINIA TECH

**INSTRUCTIONS FOR COMPLETING IMMUNIZATION INFORMATION**

**Marking: Please print using black ink.** Read carefully and fill in all applicable information. **All information regarding Immunization and Tuberculosis screening/testing must be in English.**

**Immunizations: To be completed and signed by a Health Care Provider**

**Required vaccinations/screening for all students:**

**A.** **Tetanus Diphtheria-Pertussis:** Primary series (DTap, DTP, DT or Td) plus booster **within the last 10 years of fall entry or spring entry**. Tdap is the preferred one time booster. Tdap may be given regardless of interval since last Td.

**B.** **Measles, Mumps, Rubella (MMR):** Two doses of MMR or individual vaccines **of each required**, at least 4 weeks apart, given on or after the first birthday. Not required if born before 1957. Titers proving immunity are acceptable; please provide a copy of the report with the date(s) and result(s) of positive titer(s).

**C.** **Polio:** Completed primary series is required. Please provide all dates as well as any boosters received since that date. A titer proving immunity is acceptable; please provide the date of a positive titer; please provide a copy of the report with the date and result of positive titer.

**D.** **Hepatitis B:** Students must have documentation of a completed vaccination series. The Twinrix immunization series is an acceptable alternative, as is a titer proving immunity (please provide a copy of the report with the date and result of positive titer). Students may choose to sign a waiver for this immunization.

**E.** **Meningococcal Vaccine:** For students younger than 22 years of age, one dose of vaccine required after age 16 or signed waiver. Meningitis B vaccines (Trumenba and Bexsero) do not meet this requirement.

**F.** **Tuberculosis Screening/Testing:** "Tuberculosis Screening" (page 2) is required for **all students**. "Tuberculosis Testing" (page 3) is also required for students who answer "yes" to any question on page 2. **All screening/testing must be completed on or after 3/1 (fall entry) or 7/1 (spring entry).**

**Recommended vaccinations for all students:**

**A.** **Varicella (chicken pox)**: Two doses of vaccine, at least 4 weeks apart, are **strongly recommended** for all college students without other evidence of immunity (e.g. born in the U.S. before 1980, a history of disease, or a positive antibody).

**B.** **Hepatitis A:** Either alone or in combination with Hepatitis B as Twinrix (combination of Hepatitis A & B). Entering this information in the Hepatitis B section and indicating Twinrix is sufficient documentation.

**C.** **HPV Vaccine:** The three-shot series is recommended for all females ages 11-26 and males ages 11-21. It is also approved for males up to age 26 in certain situations, see CDC guidelines.

**D.** **Neisseria meningitides (Meningitis) serogroup B vaccine:** Recommended for high risk students with a history of persistent complement component deficiencies or patients with anatomic or functional asplenia. May also be given to anyone 16-23 years old to provide short-term protection. This can be either a two or three shot series depending upon the vaccine (Trumenba or Bexsero). The same vaccine must be used for all doses.

**E.** **Influenza (Flu) vaccine:** All students are strongly encouraged to receive seasonal influenza (flu) vaccine when it is available beginning in early fall. Schiffert Health Center will sponsor a flu clinic on campus in the fall to provide students with flu vaccine.

**F.** COVID-19 Vaccine: All students must have documentation of completed series. Completed two doses of either the Pfizer-BioNTech COVID-19 vaccine OR the Moderna COVID-19 vaccine OR a single dose of the Johnson & Johnson (also known as Janssen Biotech) COVID-19 vaccine. COVID-19 vaccines authorized by the World Health Organization (e.g., AstraZeneca/Oxford and Sinopharm) are also acceptable.

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SCHIFFERT HEALTH CENTER
VIRGINIA TECH

# Certificate Of Immunization History

Name: _____ Birthday: ____/____/____
Last First Middle Month Day Year

University ID:_____ Telephone:_____ Country of Origin: _____

**Emergency Contact:** (Parent/Guardian/Spouse/Next-of-Kin) Term Entering: □ Fall □ Spring

Name:_____ Relationship to student: _____
Last First Middle

Address:_____
No. & Street City State Zip/Postal Code Country

Telephone:(_____)_____ Work/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.

| | | | | | |
|---|---|---|---|---|---|
| R | **Tuberculosis Screening** All students regardless of enrollment status are required to complete the tuberculosis screening form on page 2. | | | | |
| | **IMMUNIZATIONS** | | | | |
| R | **Tetanus, diphtheria, pertussis (Tdap)** within 10 yrs ____/____/____ | | **OR Tetanus diphtheria (Td)** within 10 yrs ____/____/____ | | |
| | **Hepatitis A** ① ____/____/____ | ② ____/____/____ | | | |
| R | **Hepatitis B** or **Hep A/B (Twinrix)** | ① ____/___/____ ② ___/____/____ ③ ___/____/____ | | | **OR** titer indicating immunity. **Must attach lab results. OR** signed waiver |
| | **Human Papillomavirus** | ① ____/____/____ ② ____/____/____ ③ ____/____/____ | | | □ Gardasil □ Cervarix |
| R | **Measles, mumps, rubella (MMR):** Received after first birthday **OR** **Measles (Rubeola)**: **Mumps:** **Rubella:** | ① ____/____/____ ② ____/____/____ ① ____/____/____ ② ____/____/____ ① ____/____/____ ② ____/____/____ | | | **OR** titer(s) indicating positive immunity **Must attach lab results.** |
| R | **Meningococcal vaccine-**students | ① ___/____/____ ② ___/____/____ | | < 22 years of age **OR** waiver signed | □ MCV4 given □ MPS4 given |
| | **Meningitis B** | ① ___/____/____ ② ___/____/____ ③ ___/____/____ | | | □ Bexsero □ Trumenba |
| | **Other Immunizations:** | _____ (Name) ____/____/____ _____ (Name) ____/____/____ | | _____ (Name) ____/____/____ _____ (Name) ____/____/____ | |
| R | **Polio IPV or OPV** | ____/____/____ ____/____/____ ____/____/____ ____/____/____ | | **OR** titer indicating positive immunity | **Must attach lab results.** |
| | **Varicella (Chicken Pox)** strongly recommended | Date of disease: ___/____/____ | **OR vaccines** ① ___/____/____ 2 doses, ≥ 1 mo. apart | ② ___/____/____ | **OR** titer indicating immunity. **Must attach lab results.** |
| R | = Required | | | | |

**Consent for the Treatment of Minors**
(Students 17 years and younger)

The Virginia Tech Schiffert Health Center has my permission to treat my minor child in the event of a medical emergency. Virginia Tech Schiffert Health Center also has my permission to treat my child for routine medical care, including check-ups, immunizations, and/or treatment for minor injuries and illnesses.

_____
Signature of Parent/Legal Guardian Date

**Hepatitis B Vaccine Waiver**
(Review page 4 prior to signing)
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

**Meningococcal Vaccine Waiver**
(Review page 4 prior to signing)
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

**COVID-19 Vaccines**

**Moderna** ①___/____/____ ②___/____/____

**Pfizer** ①___/____/____ ②___/____/____

**Johnson & Johnson** ①___/____/____

**AstraZeneca** ① ___/____/____ ②___/____/____

**Other:** _____ (Name)
①___/____/____ ②___/____/____

SIGN HERE

_____
Health Care Provider or Health Department Signature Date

**Medical Exemption -- *Does not apply to tuberculosis (TB) Screening/Testing**
As specified in the Code of Virginia §23-7.3, 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:[ ]; COVID-19:[ ] This contraindication is permanent: [ ] or temporary [ ] and expected to preclude immunizations until: Date (Mo., Day, Yr.):_____

_____
Signature of Medical Provider/Health Department Official Date

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SCHIFFERT HEALTH CENTER
VIRGINIA TECH

# TUBERCULOSIS SCREENING

Name: _____ DOB: _____ University ID #:_____

Country of Origin:_____

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 Page 3, Section C). ☐ 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 a high risk setting such as long-term care facilities, homeless shelters or correctional facilities? ☐ Yes ☐ No
4. Have you been a healthcare worker? ☐ 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, 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. Have you lived in or visited another country where TB is common for 3 months or more, regardless of length of time in the US?(If yes, please CIRCLE the country, below)? ☐ Yes ☐ No

| | | | | |
|---|---|---|---|---|
| Afghanistan | Colombia | Indonesia | Nauru | Singapore |
| Algeria | Comoros | Iraq | Nepal | Solomon Islands |
| Angola | Congo | Kazakhstan | Nicaragua | Somalia |
| Anguilla | Côte d'Ivoire | Kenya | Niger | South Africa |
| Argentina | Democratic Republic of the Congo | Kiribati | Nigeria | South Sudan |
| Armenia | Djibouti | Kuwait | Northern Mariana Islands | Sri Lanka |
| Azerbaijan | Dominican Republic | Kyrgyzstan | North Korea (Democratic | Sudan |
| Bangladesh | Ecuador | Lao People's Democratic | People's Republic) | Suriname |
| Belarus | El Salvador | Republic Latvia | Pakistan | |
| Belize | Equatorial Guinea | Lesotho | Palau | Tajikistan |
| Benin | Eritrea | Liberia | Panama | Thailand |
| Bhutan | Eswatini | Libya | Papua New Guinea | Timor-Leste |
| Bolivia | Ethiopia | Lithuania | Paraguay | Tokelau |
| Bosnia and | Fiji | Madagascar | Peru | Togo |
| Herzegovina Botswana | French Polynesia | Malawi | Philippines | Tunisia |
| Brazil | Gabon | Malaysia | Qatar | Turkmenistan |
| Brunei Darussalam | Gambia | Maldives | Republic of Korea | Tuvalu |
| Bulgaria | Georgia | Mali | Republic of Moldova | Uganda |
| Burkina Faso | Ghana | Marshall Islands | Romania | Ukraine |
| Burundi | Greenland | Mauritania | Russian Federation | United Republic of Tanzania |
| Cabo Verde | Guam | Mexico | Rwanda | Uruguay |
| Cambodia | Guatemala | Micronesia (Federated States of) | Saint Vincent and the | Uzbekistan |
| Cameroon | Guinea | Mongolia | Grenadines Sao Tome and | Vanuatu |
| Central African Republic | Guinea-Bissau | Montenegro | Principe | Venezuela |
| Chad | Guyana | Morocco | Senegal | Viet Nam |
| China | Haiti | Mozambique | Sierra Leone | Yemen |
| China, Hong Kong SAR | Honduras | Myanmar | | Zambia |
| China, Macao SAR | India | Namibia | | Zimbabwe |

☐ **I have answered "YES" to 1 or more of the above questions and must complete Page 3.**
☐ **I have answered "NO" to ALL of the above questions.** No TB test is required.

_____ _____
Signature of Student or Parent/Legal Guardian Date

I have reviewed the above Tuberculosis screening and completed page 3 if required.

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VIRGINIA TECH

# TUBERCULOSIS TESTING

Name: _____ DOB: _____ University ID #:_____

Country of Origin:_____

Students **MUST** undergo Tuberculin skin test (TST) **OR** have one Interferon Gamma Release Assay Test (IGRA) if **THEY** answered yes to 1 or more risk questions. All testing and X-rays must be done during time frames prior to semester start: **Fall start: on or after March 1| Spring start: on or after July 1**.

**A. TST**

Date placed:_____ Date read:_____ Result:_____ mm □ Positive □ Negative

A PPD/TST of ≥ 5 mm induration is considered positive for immunocomprised students
A PPD/TST of ≥ 10 mm induration is considered positive for immigrants from high prevalence countries.
A PPD/TST of ≥ 15 mm induration is considered positive for students with no risk factors.

**B. IGRA (preferred for students who have received BCG vaccine)**
Date performed:_____ Result:_____ □ Positive □ Negative (Attach copy of lab report)

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

**C. History of a prior Positive TST or IGRA**

Date of positive TST:_____ Result :_____ mm OR Date of positive IGRA: _____ □ Quantiferon Gold or □ T-Spot

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

If yes to any question, please explain further_____ __

**D. Chest X-ray Date:** _____ □ Positive □ Negative

Required **ONLY** if POSITIVE TST or POSITIVE IGRA. Chest x-ray required within six months of semester start date – **Fall: on or after March 1 | Spring: on or after July 1** – unless patient has a known prior positive TB test and is able to provide official documentation of all of the following: 1) negative chest x-ray at or after diagnosis, 2) completion of treatment for latent TB infection, and 3) negative symptom screen (above).

**E. Treatment for TB disease or Latent TB Infection** □ Completed □ Ongoing

Dates of treatment regimen: _____ to _____ (attach documentation)

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Health Care Provider (printed):_____ Health Care Provider Signature:_____

Date_____ Phone_____

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SCHIFFERT HEALTH CENTER
VIRGINIA TECH

# Waiver Information for Meningococcal Disease & Hepatitis B

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

The Code of Virginia (Chapter 340 23-7.5) requires that "All full time students, prior to enrollment in any public four-year institution of higher education, shall be vaccinated against (i) Meningitis and (ii) Hepatitis B." Institutions of higher education must provide the student or the student's parent or other legal representative detailed information on the risks associated with the Meningitis or Hepatitis B, and on the availability and effectiveness of any vaccine. The Code permits "the student or if the student is a minor, the student's parent or the legal representative to sign a written waiver stating that he/she has received and reviewed the information on Meningitis or Hepatitis B and detailed information on the risks associated with Meningitis or Hepatitis B and on the availability and effectiveness of any vaccine, and has chosen not to be or not to have the student vaccinated."

**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 plain in muscles, joints and stomach. Many people have no symptoms with the illness that leads to liver damage, liver cancer, and death.

According to the Centers for Disease Control, about 1.2 million people in the U.S. have chronic Hepatitis B infection. Each year approximately 40,000 people 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 in the U.S. 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 blood/body fluid exposure.

There are several ways to prevent Hepatitis B infections including avoiding risky behavior, screening pregnant women, and vaccination. Vaccination is the best prevention. The vaccine series typically consists of three injections given over a six month period.

***Remember: Completion of the vaccine series is needed for protection against Hepatitis B disease.***

For more detailed information please visit:
http://www.cdc.gov/ncidod/diseases/hepatitis/b/faqb.htm

**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 1,000-1,200 people get meningococcal disease each year in the U.S. Of those cases, 10-15% die and of those who live, another 11-19% may require limb amputation, have problems with their nervous system, become deaf, or suffer seizures or strokes.

College students, particularly freshmen who live in dormitories, have a 6-fold increased risk of getting meningococcal disease. The disease is spread person-to-person through the exchange of respiratory and throat secretions (e.g., by coughing, kissing, or sharing eating utensils).

**Meningococcal conjugate vaccine** (MCV4) and polysaccharide vaccine (MPSV4) are effective in preventing four types of meningococcal disease including two of the three most commonly occurring types in the U.S. It does not, however, protect against serotype B. **Meningitis B vaccine** (Trumenba or Bexsero) offers protection for serotype B. Seven outbreaks of serogroup B meningococcal disease have occurred on college campuses since 2009, resulting in 41 cases and 3 deaths (MMWR 64(411); 1171-6).

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 older than 21 years who are not at increased risk of exposure to N. Meningitides is not recommended.

In addition to the meningococcal conjugate vaccine, **Meningitis B** vaccine is recommended for high risk students with a history of persistent complement component deficiencies or patients with anatomic or functional asplenia. It may also be given to anyone 16 to 23 years old to provide short-term protection. This can be either a two- or three-shot series depending on the vaccine (Bexsero or Trumenba).

For more detailed information please visit
http://www.immunize.org/catg.d/p4210.pdf