Submitting Immunizations and Health History

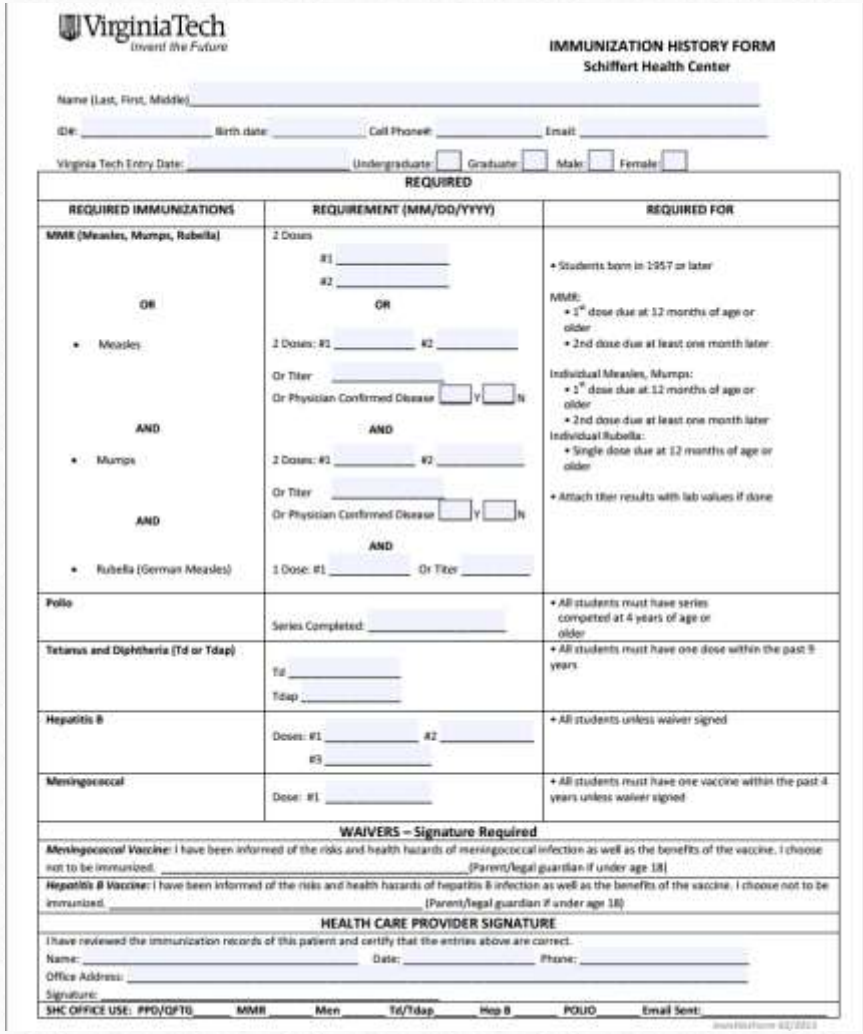
We at the Schiffert Health Center look forward to serving your health needs to ensure your academic success. To help us do so, we need information about your health status.

Immunization History Packet (REQUIRED)

To begin, download this form –

http://www.healthcenter.vt.edu/assets/docs/immunizationhistory_form.pdf

Please fill this out along with any supplemental materials



VirginiaTech
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IMMUNIZATION HISTORY FORM
Schiffert Health Center

Name (Last, First, Middle)_____

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 _____ Or Physician Confirmed Disease ☐Y ☐N AND 2 Doses: #1 _____ #2 _____ Or Titer _____ Or Physician Confirmed Disease ☐Y ☐N 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	Series Completed: _____	• All students must have 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)

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)

HEALTH CARE PROVIDER SIGNATURE

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

Name: _____ Date: _____ Phone: _____

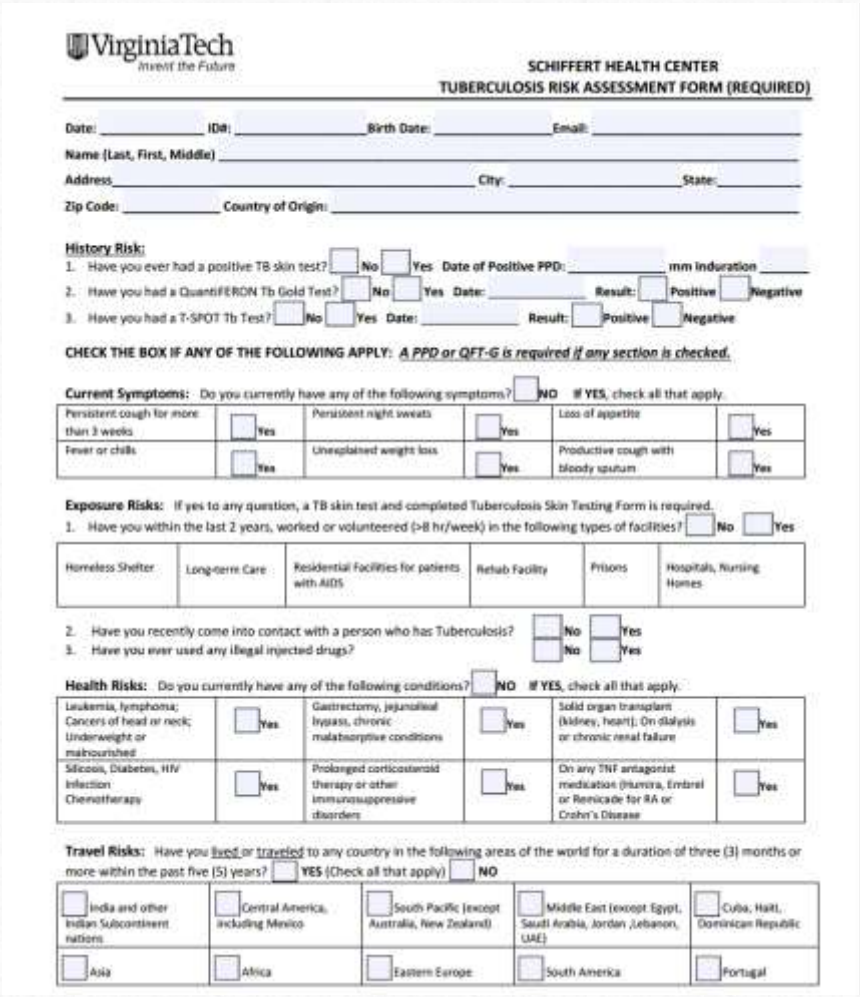
Office Address: _____

Signature: _____

SHC OFFICE USE: PPD/QFT© _____ MMR _____ Men _____ Td/Tdap _____ Hep B _____ POLIO _____ Email Sent: _____

Tuberculosis Risk Assessment Form

This Tuberculosis Risk Assessment Form is also included as part of the Immunization History Form and **is a required document for all students**.



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SCHIFFERT HEALTH CENTER
TUBERCULOSIS RISK ASSESSMENT FORM (REQUIRED)

Date: _____ **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, Enbrel 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? ☐ **YES** (Check all that apply) ☐ **NO**

☐ 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

Tuberculosis Skin Testing Form

If you answered 'Yes' to any question on the Tuberculosis Risk Assessment Form, you are required to submit the Tuberculosis Skin Testing Form.

This form is also included as part of the Immunization History Form.

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SCHIFFERT HEALTH CENTER
TUBERCULOSIS SKIN TESTING FORM

Date: _____ 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

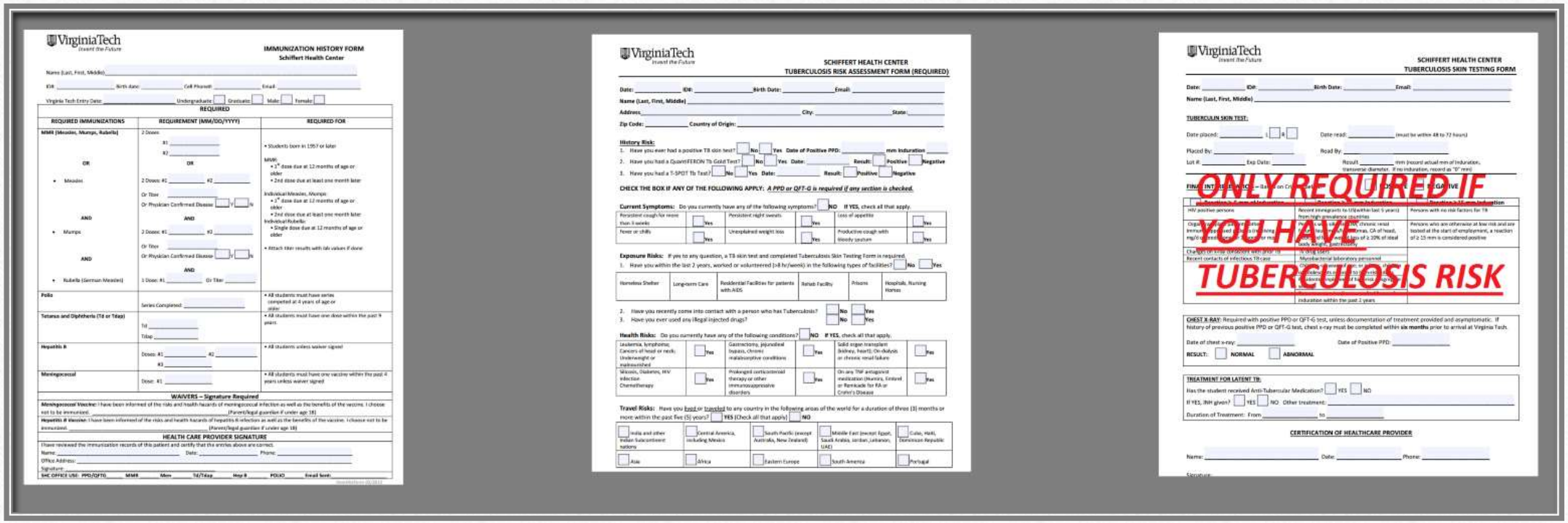
If YES, INH given? ☐ YES ☐ NO Other treatment: _____

Duration of Treatment: From _____ to _____

CERTIFICATION OF HEALTHCARE PROVIDER

Name: _____ Date: _____ Phone: _____

Signature:



Scan **all completed and signed required forms** into <u>one document</u> (pdf or tiff)

If you do not have any risk of Tuberculosis, you should only have two documents. For those who do have risk, you will have three documents.

Files

- PDF/TIFF file extension
- Please make sure your document is not upside down after scanning.
- Make sure document is complete and signed.
- Files must be under 4MB in size.
- Avoid any special characters (<, %, #, &, !, etc)
- Use short file names (example: forms.pdf)
- Recommended Browser: Internet Explorer 9+, Chrome/Firefox (Latest)
- Operating System: Windows 7 and above, Mac OS X 10.6 and above

Login

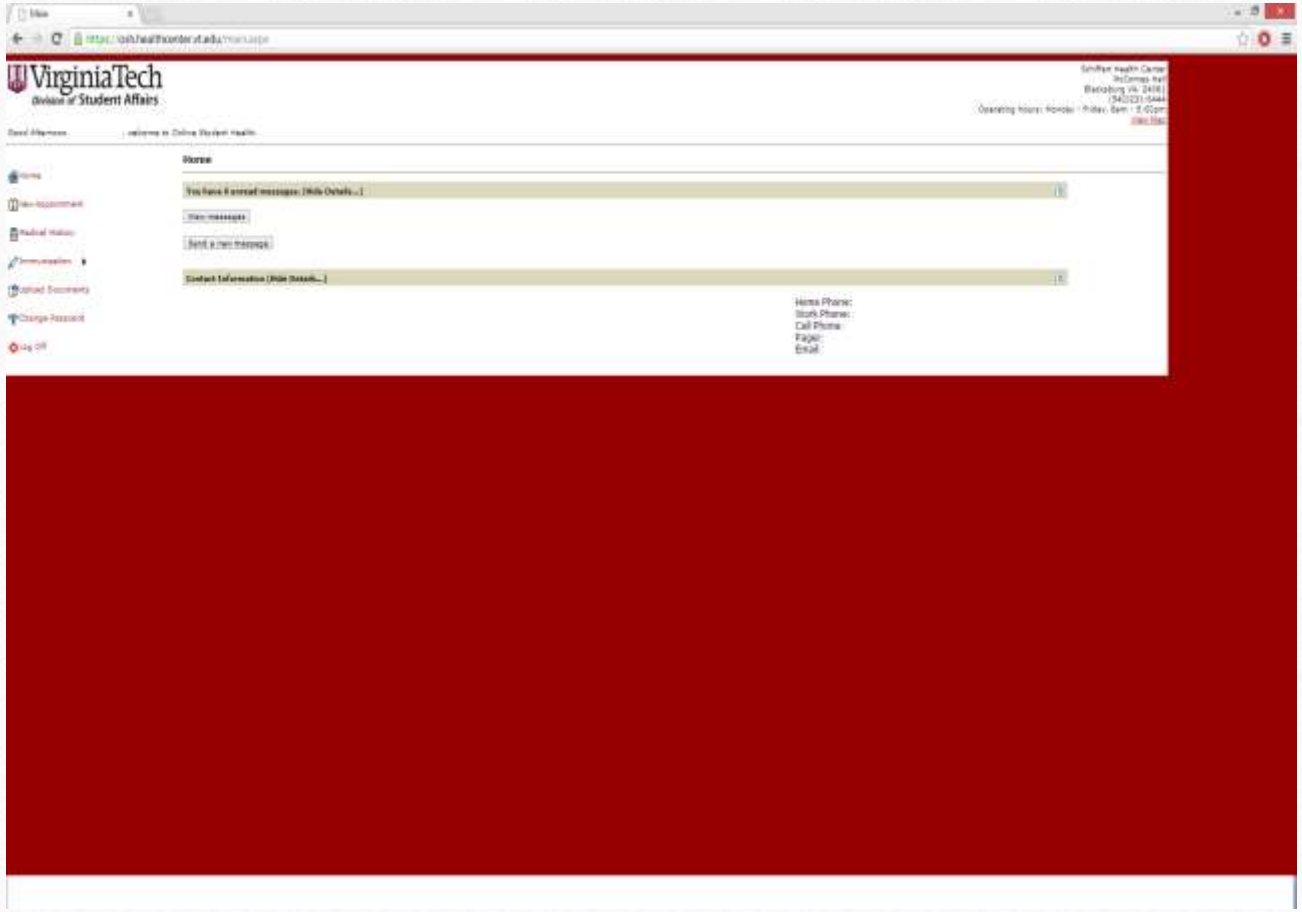
- You must have a valid Virginia Tech PID to sign-in.
- It may take up to a week after you create your PID to login to the system.

Online Student Health Portal

https://osh.healthcenter.vt.edu

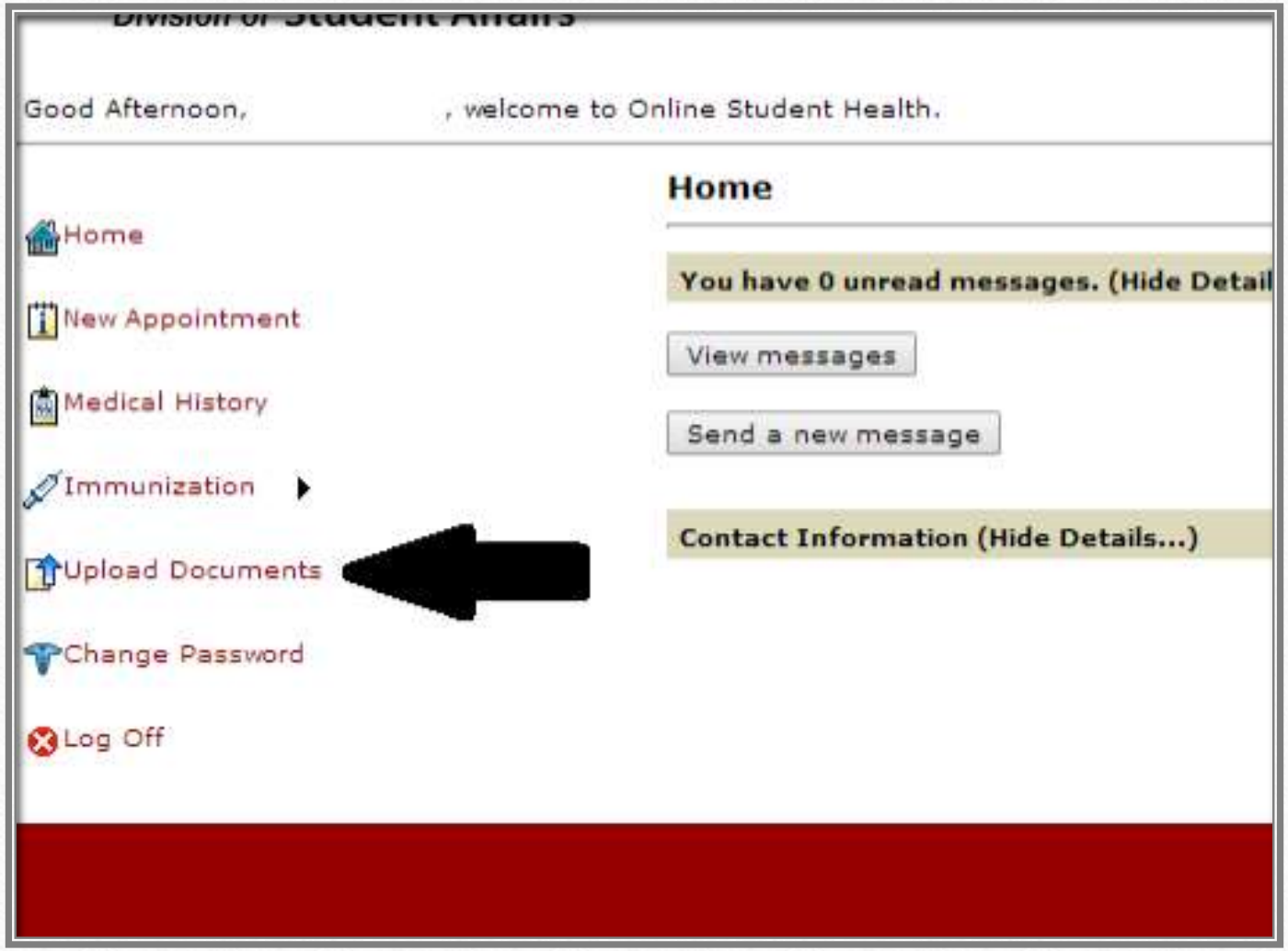
The Online Student Health Portal is your gateway to reviewing your immunization compliance, submitting documentation, and filling out your Medical History Questionnaire.

Before you can access this portal, you will need a Virginia Tech PID and PID password. If you do not know this information, please contact Virginia Tech's 4-HELP at 540-231-4357



Upload your document to the Online Student Health Portal

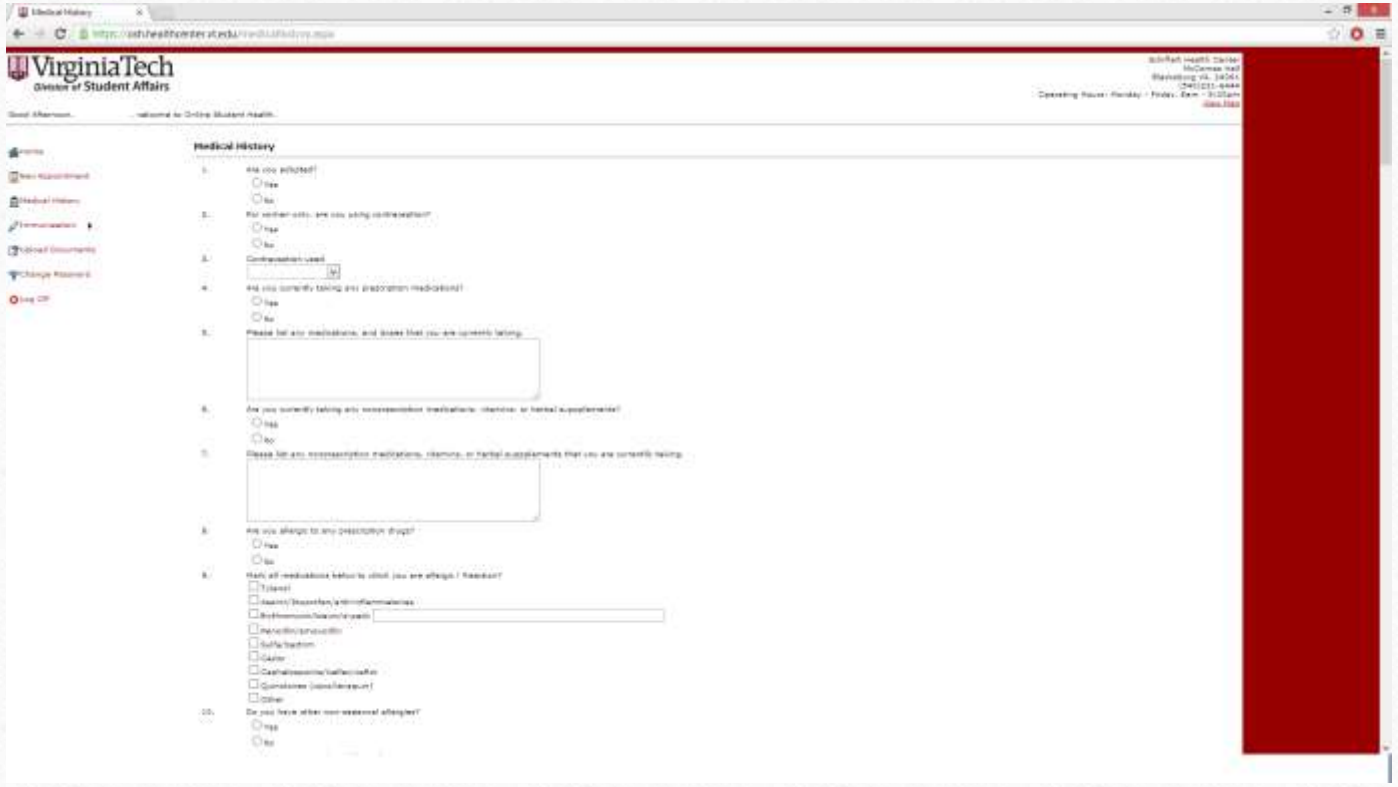
Please submit your scanned forms as a single document to the Online Student Health Portal.



Medical History Questionnaire

Within the Online Student Health Portal, select Medical History and fill out the questionnaire.

(Note: This does not substitute submitting Immunization History and TB Risk forms)



Sending by Mail

Medical Records Department

Schiffert Health Center (0140)

McComas Hall – Virginia Tech

895 Washington Street, SW

Blacksburg, VA 24061

Deliver In-Person

Medical Records

(Located through the double-doors after entering the Health Center in McComas Hall)

Drop Box

(Located Outside of Entrance to Health Center at McComas Hall)

No E-mail

Schiffert Health Center does not accept Medical Records, of any form, via electronic mail or e-mail. This is for the protection of your records.

Please make arrangements to upload via our secure Online Student Health Portal, physically mail, deliver in-person or fax your records.

Best Practices

- While not required, physically mail any additional documentation signed by your physician that is relevant to your medical history. This will provide the Schiffert Health Center with a better picture of your health, and will enable our providers to give you the best care possible.
- Submit all paperwork 1 month prior to the start of classes.