

Students cannot register for classes until they have fulfilled the required immunizations
Compliance & exemption information can be reviewed at: www.buffalo.edu/studentlife/immunize

2026-2027 Health Background Form

This form is for all NEW INCOMING STUDENTS

University at Buffalo Student Health Services
4350 Maple Road, Amherst, NY 14226
Phone 716-829-3316 Fax: 716-829-2564
Submit via patientportal.buffalo.edu

Name (please print): _____ UB Person #: _____
Last First MI

Birthdate: _____ Academic Program/Major: _____
Month Day Year

Emergency Contact Name & Phone#: _____

FOR STUDENTS UNDER 18 YEARS OF AGE ONLY

To avoid delays when medical problems arise, we request that the following statement be signed by a parent or legal guardian:
I hereby grant permission to UB Student Health Services to provide services, including telemedicine, to my child. This includes care and treatment by medical providers at any outside health care facility if deemed necessary by UB Student Health Services.

Parent/Guardian Signature _____ Relationship _____ Date _____

Section 1. Required for ALL Students

Submit dates in MM/DD/YYYY format

MMR (combined Measles, Mumps, Rubella)

New York State Public Health Law requires documentation of:

- Two doses of MMR vaccine (given after 01/01/1968); both administered after first birthday and at least 28 days apart. Individual measles, mumps & rubella vaccines are also acceptable.

OR

- Serology (blood test): *Positive IgG antibody titers confirming immunity to measles, mumps, and rubella

Dose #1 ____/____/____

Dose #2 ____/____/____

OR

MMR Titer* Date ____/____/____

***MUST ATTACH LAB REPORT WITH REFERENCE RANGE**

MENINGOCOCCAL VACCINE or WAIVER

New York State Public Health Law requires all college students to:

- Receive *at least* one dose of Meningococcal ACWY-containing vaccine within 5 years of entering college

OR

- Receive two doses (full series) of Meningococcal B vaccine

OR

- Sign a waiver specifically declining meningococcal immunization after reading the information about meningococcal meningitis disease, found here: <https://www.health.ny.gov/publications/2168/>
Note: if you have already signed this waiver in your UB HUB Student Center, you do not need to sign it again here.

Dose 1 ____/____/____ Circle: ACWY or ABCWY

Dose 2 ____/____/____ Circle: ACWY or ABCWY

OR

Men B Dose 1 ____/____/____ Circle: Trumenba or Bexsero

Men B Dose 2 ____/____/____ Circle: Trumenba or Bexsero

OR

I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I will not obtain immunization against meningococcal meningitis disease.

Signature _____ Date _____

If student is under 18 years of age, parent/guardian must sign & date.

Health care provider signature REQUIRED to certify immunization in Section 1

Health Care Provider Signature _____ Health Care Provider Name (Print/Stamp) _____

Date _____ Health Care Provider Address & Phone Number (Print/Stamp) _____

**Section 2. Required for Health-Related Students
 Recommended for All Other Students** **Submit dates in MM/DD/YYYY format**

New students in (not intended) health-related programs: Athletic Training, Communicative Disorders, Dental, Exercise Science, Genetic Cnsl MS, Medical Laboratory, Medicine, Nuclear Medicine, Nursing, Occupational Therapy, PharmD, Physical Therapy.

<p>HEPATITIS B</p> <ul style="list-style-type: none"> 3-dose vaccine series required. <i>List dates & brand of vaccine (Heplisav-B meets requirement with 2-dose series. Recombivax-HB meets requirement with 2-dose series IF given between ages 11-15)</i> Serology: In addition to vaccination, a positive Hepatitis B Surface Antibody, Quantitative Titer (blood test confirming immunity) is REQUIRED for first-year medical and first-year dental students (including IDP). The titer is recommended for students in all other health-related programs. 	<p>Dose #1 ____/____/____ _____</p> <p>Dose #2 ____/____/____ _____</p> <p>Dose #3 ____/____/____ _____</p> <p>Hepatitis B Surface Ab, Quantitative* ____/____/____</p> <p style="text-align: center;">*MUST ATTACH LAB REPORT WITH REFERENCE RANGE</p>
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<p>TETANUS-DIPHTHERIA</p> <ul style="list-style-type: none"> Tetanus (Td/Tdap) booster within last 10 years One lifetime adult Tdap (contains pertussis) is required Must complete both fields even if the date is the same 	<p>Most recent Tetanus Booster: ____/____/____ Circle: Td or Tdap</p> <p>Adult Tdap Vaccine: ____/____/____</p> <p>Complete both fields even if the date is the same</p>
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<p>VARICELLA</p> <p>Must demonstrate immunity through <u>one of the following</u>:</p> <ul style="list-style-type: none"> Two doses of varicella vaccine; both administered <u>after</u> first birthday and at least 28 days apart <li style="text-align: center;">OR Medical provider/clinician documented history of varicella (<i>chickenpox</i>) or <i>herpes zoster (shingles) infection</i> <li style="text-align: center;">OR Serology (blood test): Positive varicella IgG antibody titer <u>confirming immunity</u> 	<p>Dose #1 ____/____/____</p> <p>Dose #2 ____/____/____</p> <p style="text-align: center;">OR</p> <p>Medical Provider/Clinician Date of Diagnosis ____/____/____</p> <p style="text-align: center;">OR</p> <p>Varicella Titer* Date ____/____/____</p> <p style="text-align: center;">*MUST ATTACH LAB REPORT WITH REFERENCE RANGE</p>
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INFLUENZA One dose annually; updated seasonal flu vaccines typically available starting late summer each year. Submit Vaccine Administration Record once immunization is obtained.

Health care provider signature REQUIRED to certify immunization in Section 2

Health Care Provider Signature	Health Care Provider Name (Print/Stamp)
Date	Health Care Provider Address & Phone Number (Print/Stamp)

**Section 3. Physical Exam within past year.
 REQUIRED for 1st year Dental, International Dental Program (IDP), 3rd Year Nursing & ABS Nursing.
 Optional for all others**

Exam Findings: _____

To the best of my knowledge, this patient is free of any physical or mental impairment which is of potential risk to patients/personnel, or which might interfere with the performance of their duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, and other drugs.

If the provider cannot certify, an explanation letter with medical provider signature must accompany this form.

Health Care Provider Signature	Health Care Provider Name (Print/Stamp)
Date	Health Care Provider Address & Phone Number (Print/Stamp)

Name (print): _____ Birthdate: _____ UB Person #: _____
Last First

Section 4. Tuberculosis Screening:
Part A REQUIRED for ALL Students
Part B REQUIRED if any response in Part A is YES or the student is enrolling in a health-related program

PART A:

- | | | | |
|-----------|--|---------------|----|
| 1. | Are you enrolling in a health-related program?
Athletic Training, Communicative Disorders, Dental, Exercise Science, Genetic Cnsl MS, Medical Laboratory, Medicine, Nuclear Medicine, Nursing, Occupational Therapy, PharmD, Physical Therapy | CIRCLE | |
| | | YES | NO |
| 2. | Have you ever had a positive PPD, TB QuantIFERON, or T-SPOT test? | YES | NO |
| 3. | Have you lived in or had an extended stay (≥ 1 month) in a country with a high TB rate?
Any country other than the United States, Canada, Australia, New Zealand, and those in Northern or Western Europe. | YES | NO |
| 4. | Are you currently on or plan to begin immunosuppression?
Including human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥ 1 month) or other immunosuppressive medication. | YES | NO |
| 5. | Have you had close contact with someone with infectious TB disease? | YES | NO |

Student Signature _____ Date _____

PART B: If the student answered YES to any of the above questions, a TB test (PPD, T-SPOT, or TB QuantiFERON {QFT}) is REQUIRED and Part B must be completed and signed by a licensed medical provider.

- TB test must be completed within one calendar year (*unless history of positive TB test – see below*).
- **MUST ATTACH LAB REPORT IF T-SPOT or QFT IS COMPLETED**
- If PPD result ≥ 10mm, or T-SPOT or QFT is positive, a chest x-ray is REQUIRED
- If questions #4 or #5 in Part A are YES & PPD ≥ 5mm, a chest x-ray is REQUIRED.
- If the student has a history of a positive TB test, document date and result of the test and chest x-ray, as well as treatment information.
- If the student has a history of a positive TB test & normal chest x-ray, it is *not necessary* for students to repeat TB testing or the chest x-ray.
- History of BCG vaccination does not exclude the student from this requirement.

PPD Date Placed:	PPD Date Read:	Induration/ Measurement (in mm):	
OR			
Circle Test*: QFT or T-SPOT *MUST ATTACH LAB REPORT	Date of Collection: ____/____/____	Circle Result Positive Negative	<i>An indeterminate, equivocal, borderline or invalid result is not acceptable. Repeat testing will be necessary.</i>

***Chest X-ray & questions below are REQUIRED if PPD ≥ 10mm or Positive QFT/T-SPOT or Part A, #4 or #5 is YES and PPD ≥ 5mm**

Chest X-Ray Date:	Chest XRay Result (Attach copy of radiology report):
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- In the past year, has the patient had any of the following symptoms: unexplained fever > 3 weeks, cough > 3 weeks with sputum production, bloody sputum, unintended weight loss > 10 pounds, drenching night sweats, unexplained fatigue > 3 weeks?

YES* NO

****If "YES", patient must be evaluated by a medical provider to rule out active TB infection***
- If positive TB test & **abnormal** chest x-ray, was active TB infection ruled out? **YES NO**
- If positive TB test & **normal** chest x-ray, did the student complete a course of TB treatment? **YES NO**
 - a. If yes, name & dose of medication _____
 - b. Date range of treatment _____ Number of months of treatment _____

Health Care Provider Signature _____ Health Care Provider Name (Print/Stamp) _____

Date _____ Health Care Provider Address & Phone Number (Print/Stamp) _____