Students cannot register for classes until they have fulfilled the immunization and meningitis information requirements.

2017-2018 Health Background Form

University at Buffalo Student Health Services
Michael Hall, 3435 Main Street, Buffalo, NY 14214-8003
Phone: 716-829-3316 Fax: 716-829-2564

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 delay in treatment when medical problems arise, we request that the following statement be signed by a parent or legal guardian:
I hereby grant permission to the healthcare providers and nurses of the University at Buffalo Student Health Services to evaluate and treat my son/daughter/ward in case of illness/injury. I also hereby grant permission to immunize my son/daughter/ward in cases where immunization is necessary as part of a treatment plan or when needed for prevention of illness.

Parent/Guardian Signature Relationship Date

Part 1 Required Vaccines

Must be completed and signed by a healthcare provider or attach immunization records from previous school, healthcare provider or government agency. Exemption info.www.buffalo.edu/studentlife/immunize

MMR (Measles, Mumps, Rubella) ***REQUIRED***

Vaccination	Vaccine Date (Month/Day/Year)	*Or* Attach Serology Results/Date
2 MMR's (measles, mumps & rubella vaccine) 1st dose after 1st birthday; 2nd dose at least 28 days later OR individual vaccines below	#1 #2	
2 MEASLES 1st dose after 1st birthday; 2nd dose at least 28 days later	#1 #2	Must attach lab results
1 MUMPS after 1st birthday		Must attach lab results
1 RUBELLA after 1st birthday		Must attach lab results

Meningitis Information Form ***REQUIRED***

New York State Public Health Law requires all students to verify that they have received information about meningococcal disease and made an informed decision about immunization. Review this information at www.buffalo.edu/studentlife/immunize

Choose one of the following:

☐	**Meningitis ACWY (within 5 years)**	**Vaccination Date:**
☐	**Meningitis WAIVER**	I acknowledge the risks associated with meningitis and refuse immunization. Student sign & date if 18 years of age or older; Parent/guardian sign & date if under 18 years of age

Part 2 Recommended Vaccines

*Students in health-related profession programs are **required** to provide proof of PPD (see Part 3C), Tetanus (within 10 years), Hepatitis B series, and Varicella vaccine or history of disease. Your academic program may also require an annual influenza vaccine.

Positive titers are an acceptable substitute for Hepatitis B and/or Varicella: Must attach lab results to be considered valid.

Vaccination	Vaccine Date(s) (Month/Day/Year)		
Hepatitis A	#1	#2	
Hepatitis B*	#1	#2	#3
Human Papilloma (HPV)	#1	#2	#3
Influenza (Date of most recent dose)			
Meningitis Serogroup B	#1	#2	#3
	Circle: Bexsero (2 doses) Trumenba (3 doses)		
Tetanus*			
	Circle: Td Tdap		
Varicella*	#1	#2	Or year of chicken pox

An official stamp and/or an authorized signature from a healthcare provider must appear on this form or it will not be accepted.

Signature/Stamp of health care provider **Date**

Phone number of practice

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

Country of Birth: _____ Year arrived in US: _____

Part 3 Mandatory Tuberculosis Screening Form *REQUIRED*

Sections A and B are REQUIRED for ALL students.

SECTION A:

1. Have you ever had a positive PPD, TB Quantiferon test, or T-SPOT? **YES ☐ NO ☐**

If yes, please provide details in Section C below.

SECTION B:

1. Were you born in, or have you lived, worked or visited for more than one month in any of the following: Asia, Africa, South America, Central America or Eastern Europe? **YES ☐ NO ☐**

   If yes, what country? _____ How long? _____

2. Do any of the following conditions or situations apply to you?
   a) Do you have a persistent cough? (3 weeks or more), fever, night sweats, fatigue, loss of appetite, or weight loss? **YES ☐ NO ☐**
   b) Have you ever lived with or been in close contact to a person known or suspected of being sick with TB? **YES ☐ NO ☐**
   c) Have you ever lived, worked, or volunteered in any homeless shelter, prison/jail, hospital or drug rehabilitation unit, nursing home or residential healthcare facility? **YES ☐ NO ☐**

Student Signature _____ Date _____

If you answered no to all of the above questions, skip Section C.

If you answered yes to any of the above questions, your health care provider must complete Section C below.

SECTION C: ATTENTION HEALTH CARE PROVIDER: If patient answered YES to any of the above questions, proof of a PPD, QuantiFERON –TB Gold or T-Spot is REQUIRED. If PPD results are 10mm or more, or QuantiFERON-TB Gold or T-Spot are positive a chest x-ray is REQUIRED. Testing and/or chest x-ray must be done within one calendar year prior to admittance (unless history of positive PPD). If student has history of positive PPD, chest x-ray is required. History of BCG vaccination does not prevent testing of a member of a high risk group.

PPD Date Placed:	PPD Date Read:	Measurement in mm induration:
OR		
QuantiFERON-TB Gold or T-Spot Result Date:	QFT-G or T-Spot Result: Positive Negative Equivocal **Circle and attach lab report**	

If PPD results are 10mm or more, or QuantiFERON-TB Gold or T-SPOT results are positive a chest x-ray is REQUIRED.

Chest X-Ray Date:	Chest X-Ray Result:

If negative CXR and positive PPD/Lab Result, did the patient complete a course of INH or other TB Treatment? YES ☐ NO ☐

If yes, name & dose of medication: _____

Date Range of Treatment: _____ **How many months did student take medication?** _____ **(# of months)**

PROVIDER INFORMATION REQUIRED

_____ _____ _____
Signature/Stamp of health care provider Phone number of practice Date

Part 4 Physical Examination

Only REQUIRED for 1st Year Dental and 3rd Year Nursing students. Must be completed and signed by a licensed healthcare provider.

Height:_____ Weight:_____ Blood Pressure:_____

Any significant history, physical exam findings, regular medications, or restriction of activity?

_____

_____

_____ _____ _____
Signature/Stamp of health care provider Phone number of practice Date