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

2017-2018 Health Background Form

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

Birthdate: ___________________________ / ___________________________ / ___________________________ Academic Program/Major: ___________________________

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 ___________________________ ___________________________

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 make 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.

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>Vaccine Date(s) (Month/Day/Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A</td>
<td>#1 #2</td>
</tr>
<tr>
<td>Hepatitis B*</td>
<td>#1 #2 #3</td>
</tr>
<tr>
<td>Human Papilloma (HPV)</td>
<td>#1 #2 #3</td>
</tr>
<tr>
<td>Influenza (Date of most recent dose)</td>
<td></td>
</tr>
<tr>
<td>Meningitis Serogroup B</td>
<td>#1 #2 #3</td>
</tr>
</tbody>
</table>

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 Name First Name 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.

<table>
<thead>
<tr>
<th>PPD Date Placed:</th>
<th>PPD Date Read:</th>
<th>Measurement in mm induration:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>OR</td>
</tr>
<tr>
<td>QuantiFeron-TB Gold or T-Spot Result Date:</td>
<td>QFT-G or T-Spot Result:</td>
<td>Positive</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Circle and attach lab report</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Chest X-Ray Date:</th>
<th>Chest X-Ray Result:</th>
</tr>
</thead>
</table>

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: __________________________

<table>
<thead>
<tr>
<th>Date Range of Treatment:</th>
<th>How many months did student take medication? (# of months)</th>
</tr>
</thead>
</table>

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 ________________