2025-2026 Health Background Form

- This form is for all NEW INCOMING STUDENTS
- Returning health-related program students, please use the Annual Immunization Review form

University at Buffalo Student Health Services
4350 Maple Road, Amherst, NY 14226
Phone 716-829-3316 Fax: 716-829-2564

Students cannot register for classes until they have fulfilled the required immunizations

- Form must be completed and signed by a licensed health care provider or have immunization records attached.
- All immunization records must be in English.
- Submit to UB Student Health Services via the patient portal (patientportal.buffalo.edu).
- Exemption information can be reviewed at: www.buffalo.edu/studentlife/immunize

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____/____/_____ Men B Dose #2____/____/_____ **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.***

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

Section 2. Required for Health-Related Students Recommended for All Other Students	**Submit dates in MM/DD/YYYY format**
New students enrolled (not *intended*) in **health-related programs include:** Athletic Training, Communicative Disorders, Dental, Dietetic Intern, Exercise Science, Medicine, Medical Technology/Biotechnology, Nuclear Medicine, Nursing, Occupational Therapy, Pharmacy, Physical Therapy.	
HEPATITIS B • 3-dose vaccine series required. *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)* • Serology: In addition to vaccination, a positive Hepatitis B Surface Antibody, **Quantitative** Titer (blood test confirming immunity) is **REQUIRED** for all first-year medical students. The titer is recommended for students in all other health-related programs.	Dose #1____/____/____ _____ Dose #2____/____/____ _____ Dose #3____/____/____ _____ Hepatitis B Surface Ab, Quantitative* ____/_____/_____ ***MUST ATTACH LAB REPORT WITH REFERENCE RANGE***
TETANUS-DIPHTHERIA • 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	Most recent Tetanus Booster: ___/___/_____ *Circle:* **Td** *or* **Tdap** ☐ ☐ Adult **Tdap** Vaccine: _____/____/_____ ***Complete both fields even if the date is the same***
VARICELLA Must demonstrate immunity through one of the following: • Two doses of varicella vaccine; both administered after first birthday and at least 28 days apart **OR** • Medical provider/clinician documented history of varicella *(chickenpox) or herpes zoster (shingles) infection* **OR** • Serology (blood test): Positive varicella IgG antibody titer confirming immunity	Dose #1____/____/_____ Dose #2____/____/_____ **OR** Medical Provider/Clinician Date of Diagnosis____/____/____ **OR** Varicella Titer* Date ___/_____/_____ ***MUST ATTACH LAB REPORT WITH REFERENCE RANGE***
INFLUENZA • One dose given annually during flu season. List date given & brand of vaccine.	____/____/_____ _____

Section 3. Recommended for All Students	**Submit dates in MM/DD/YYYY format**
HEPATITIS A	Dose #1_____/_____/_____ Dose #2_____/_____/_____
HUMAN PAPILLOMA VIRUS (HPV)	Dose #1_____/_____/_____ Dose #2_____/_____/_____ Dose #3_____/_____/_____
POLIO	Dose #1_____/_____/_____ Dose #2_____/_____/_____ Dose #3_____/_____/_____ Dose #4_____/_____/_____
COVID-19 VACCINE • List date of most recent dose & brand of vaccine	_____/____/_____ _____

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

Section 4. Health Care Provider Signature REQUIRED to Certify Immunizations in Section 1, 2 and 3

_____

Health Care Provider Signature Date

_____

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

Section 5. Physical Exam within past year
REQUIRED for 1st year Dental, International Dental Program(IDP), 3rd Year & ABS Nursing
Optional for all other students

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 Date

_____

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

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

Section 6. Tuberculosis Screening: Parts A & B REQUIRED for ALL Students
Part C REQUIRED if YES to any question in Parts A or B

PART A: **CIRCLE**

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

PART B:

1. Are you currently enrolled (**not *intended*)** in a health-related program (Athletic Training, Communicative Disorders, Dental, Dietetic Intern, Exercise Science, Medicine, Med Tech/Bio Tech, Nuclear Med, Nursing, OT, Pharmacy, PT)? ☐**YES** **NO**☐
2. Were you born in or have you resided for more than one month in a country other than the U.S., Canada, Australia, New Zealand or those in Northern or Western Europe? ☐**YES** **NO**☐

   If yes, what country?_____ How long? _____
3. Do any of the following conditions or situations apply to you?

   a. Have you been in close contact to someone who has infectious TB infection since your last TB test? ☐**YES** **NO**☐

   b. Have you ever lived, worked, or volunteered in congregate settings (e.g., prisons, nursing homes, homeless shelters, drug treatment facilities or healthcare facilities)? ☐**YES** **NO**☐

   c. Do you have a medical condition or are you taking medication which suppresses your immune system? ☐**YES** **NO**☐

Student Signature_____ Date _____

PART C: IF "YES" TO ANY OF THE QUESTIONS above, IT IS REQUIRED THAT THE FOLLOWING SECTION BE COMPLETED BY A MEDICAL PROVIDER.

- If the student answered YES to any of the above questions, a TB test (PPD, T-SPOT, or TB QuantiFERON {QFT}) is REQUIRED.
  - 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 is 10mm or more, or T-SPOT or QFT is positive, 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.
  - It is *not necessary* for students with a history of a positive TB test & normal chest x-ray 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 ☐	*An indeterminate, equivocal, borderline or invalid result is not acceptable. Repeat testing will be necessary.*

***Chest X-ray REQUIRED IF PPD ≥ 10mm *or* Positive QFT/T-SPOT. Please attach copy of radiology report.**

Chest X-Ray Date:	Chest XRay Result:

1. Does the student have any of the following symptoms: cough with sputum production > 3 weeks, bloody sputum, unintended weight loss > 10 pounds, drenching night sweats, unexplained fever, fatigue > 3 weeks? ☐**YES** **NO**☐
   If yes, student must be evaluated by a medical provider to rule out active TB infection
2. If positive TB test & normal chest x-ray, did the student complete a course of INH or other 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 Date

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