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

This form must be completed and signed by a licensed health care provider or attach immunization records. Records must be in English. Exemption information can be reviewed at buffalo.edu/studentlife/immunize

2022-2023 Health Background Form

University at Buffalo Student Health Services
Phone: 716-829-3316 Fax: 716-829-2564

Form for all incoming students who are new to UB
Returning Health-Related students use the Annual Immunization Review form

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

1. Required Immunizations for All Students	Please submit dates in MM/DD/YYYY format
MMR (combined Measles, Mumps, Rubella) Two doses required after 1st birthday and at least 28 days apart given after 01/01/1968 **OR** Titer (blood test, serology) confirming immunity. Lab results with reference range must be attached.	Dose #1 ____/____/_____ Dose #2 ____/____/_____ **OR** ☐ Titer attached; positive/confirming immunity ***Must attach lab results with reference range***
MENINGOCOCCAL VACCINE (ACWY or B) or WAIVER New York State requires all college students to receive meningococcal vaccine within 5 years of entering college or sign a waiver specifically declining the immunization.	Men ACWY Dose #1 ____/____/_____ **OR** Men B Dose #1 ____/____/_____ Men B Dose #2 ____/____/_____ **OR** I acknowledge the risks associated with meningitis and refuse immunization. _____ Signature Date **Student sign & date if 18 years of age or older;** Parent/guardian sign & date if under 18 years of age
COVID-19 PRIMARY VACCINE All students are required to have completed the primary COVID-19 vaccination. Include manufacturer's name (i.e. Pfizer, Moderna, Sinovac, etc.) on blank line. A copy of the student's CDC Vaccination Card or International government record should be attached. Once time eligible, the booster is strongly encouraged.	Dose #1 ____/____/_____ _____ Manufacturer name Dose #2 ____/____/_____ _____ Manufacturer name Booster ____/____/_____ _____ Manufacturer name

2. Required for Health-Related Students. Recommended for All Other Students — Please submit dates in MM/DD/YYYY format

New students enrolled (not *intended*) in health-related programs are required to provide proof of TB testing (see 6C), Tetanus vaccine (within 10 years), Hepatitis B and Varicella immunity. For 1st year medical students, a Hepatitis B quantitative antibody titer report is required. Positive titers are acceptable proof of immunity for Hepatitis B and Varicella. Lab report must be attached to this form to be considered valid.

HEPATITIS B Series of three doses required (if Heplisav-B given, only 2 doses required	Dose #1 ____/____/_____ Dose #2 ____/____/_____ Dose #3 ____/____/_____ **OR** Hepatitis B Titer Date ____/____/_____ ***Must attach lab result with reference range***	
TETANUS-DIPHTHERIA Tetanus booster within 10 years. At least one lifetime, adult Tdap (pertussis booster). Complete both fields even if same date. Circle type of vaccine received.	Date of most recent Tetanus. Circle type: Circle: **Td** **Tdap**	Date of 1 lifetime, adult Tdap (pertussis booster):
VARICELLA Two doses of vaccine or date of clinician diagnosis (non-clinician diagnosis is not acceptable).	Dose #1 ____/____/_____ Dose #2 ____/____/_____ **OR** Date of clinician diagnosis ____/____/_____ **OR** Varicella Titer Date ____/_____/_____ ***Must attach lab result with reference range***	

3. Recommended for All Students — Please submit dates in MM/DD/YYYY format

HEPATITIS A	Dose #1 ____/____/_____ Dose #2 ____/____/_____
HUMAN PAPILLOMA VIRUS (HPV)	Dose #1 ____/____/_____ Dose #2 ____/____/_____ Dose #3 ____/____/_____

4. Health Care Provider Signature Required to Certify Immunizations in sections 1, 2, & 3

_____

Health Care Provider Signature — Health Care Provider Printed/Stamped Name

_____

Health Care Provider Phone — Health Care Provider Printed/Stamped Address

5. Physical Exam within past year is REQUIRED for 1st Year Dental & 3rd Year Nursing Students. Optional for all other students.

Height:_____ Weight:_____ Blood Pressure:_____ 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 provider cannot certify, an explanation letter with medical provider signature must accompany this form.

_____

Health Care Provider Signature — Health Care Provider Printed/Stamped Name

_____

Health Care Provider Phone — Date of Physical Exam

6. Tuberculosis Screening Sections A & B Required for All Students; Section C is Required as Directed in Sections A & B.

SECTION A: (circle Yes or No)

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: (circle Yes or No)

1. Are you currently enrolled (**not *intended***) in a health-related program (Athletic Training, 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 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? _____
3. 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 medical provider must complete Section C below.

SECTION C: ATTENTION MEDICAL PROVIDER: If patient answered YES to any of the above questions, a TB test (PPD, T-Spot, or TB QuantiFERON) is REQUIRED. History of BCG vaccination does not exclude patient from this requirement. Test must be done within one calendar year (unless history of positive TB test). If PPD results are 10mm or more, or T-Spot or TB QuantiFERON are positive, a chest x-ray is REQUIRED. **For students with history of positive TB test, documentation of dates & results of testing and chest x-ray, as well as treatment information, must be documented below**. It is not necessary for these students to repeat TB testing or CXR.

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)

_____

Health Care Provider Signature Health Care Provider Printed/Stamped Name

_____

Health Care Provider Phone Health Care Provider Printed/Stamped Address