HEALTH & IMMUNIZATION FORM

WORCESTER STATE UNIVERSITY

Mail completed form to:
Worcester State University
Student Health Services
486 Chandler Street
Worcester, MA 01602

Phone: 508-929-8875
Fax: 508-929-8075
Email: health_services@worcester.edu

Please check all appropriate boxes:

☐ Commuter ☐ Campus resident ☐ First Year ☐ Graduate ☐ Transfer
☐ Athlete ☐ IELI ☐ Exchange ☐ Nursing, OT, CD Status: ☐ PT ☐ FT

1. GENERAL INFORMATION: TO BE COMPLETED BY STUDENT

Legal Name_____
Last First Middle

Chosen Name (optional)_____

Birthdate_____ Birthplace_____
Month Day Year

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Decline to State

State Gender Identity: ☐ Male ☐ Female ☐ Transgender Man ☐ Transgender Woman ☐ Gender Non-Conforming ☐ Not Listed ☐ Decline to State

Permanent Home Address:_____
No. Street

_____
City State Zip

Student's Cell# _(_____)_____

Parents's Name _____
Last First Middle

Home Address_____
No. Street

_____
City State Zip

Cell Phone (_____)_____

Parents's Name _____
Last First Middle

Home Address_____
No. Street

_____
City State Zip

Cell Phone _(_____)_____

Someone other than parents to be notified in case of emergency (if parents are unavailable):

Name_____ Phone Number (_____)_____

Do you have any allergy to medication? ☐ Yes ☐ No

Please list:_____

Do you have any serious medical condition? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

FOR OFFICE USE ONLY

Student ID_____ WSU Email_____

II. MEDICAL HISTORY: ***To be completed by the student***

Please complete this form before going to your physician for examination.

Have you ever had or have you now a problem with (check at right of each item): *(Explain YES answers below)*

Check each item:	Yes	No		Yes	No		Yes	No		Yes	No
Head & nervous system			Poor teeth/toothaches			Hepatitis or jaundice			Exposure to DES		
Headaches			Gum Disease			Genitourinary system			Infectious disease		
Fainting			Heart, Lungs			Blood in urine			Mononucleosis		
Severe head injury			High blood pressure			Cystitis			Chicken pox		
Seizures/convulsions			Heart murmur			Kidney infection/disease			TB or positive skin test		
Dizzy spells			Heart trouble			Menstrual disorder			Past illnesses		
Insomnia			Palpitations			Bones, joints			Operations		
Eyes			Shortness of breath			Fractures/dislocations			Serious injuries		
Blindness			Chronic cough			Knee problems			Serious illness		
Double vision			Pneumonia			Deformity			Substance abuse		
Deafness, hearing aid			Asthma			Arthritis			Psychological illness		
Perforated eardrum			Bronchitis			Back problems			Medication allergy —		
Frequent ear infections			Digestive system			Tumor or growth			please list:		
Frequent nose bleeds			Abdominal pain			Skin disorder					
Frequent sore throats			Diarrhea; chronic/recurrent			Diabetes					
Neck			Colitis, ileitis			High cholesterol			Other Allergies:		
Frequent swollen glands			Irritable bowel			Eating disorder					
Thyroid dysfunction			Gall stones			Sickle cell trait/disease					

Explanation of YES answers:_____

_____

_____

III. PHYSICAL EXAMINATION: TO BE COMPLETED BY HEALTH CARE PROVIDER*.

***Note: Provider may submit a printout of the Physical and Immunization Record.**

Name:_____
Last First Middle

Height:_____ BP:_____/_____ Right Vision_____ Left Vision_____

Weight:_____ Pulse:_____ Resp:_____ ☐ Glasses: Right Vision_____ Left Vision_____

	System	Normal	Abnormal		System	Normal	Abnormal
1	Skin			11	Hernia		
2	Ears			12	Genitalia		
3	Eyes			13	Pelvic (if indicated)		
4	Nose, throat, teeth			14	Rectal		
5	Neck, thyroid			15	Lymphatic		
6	Chest, breasts			16	Extremities		
7	Lungs			17	Neurological		
8	Heart			18	Psychological		
9	Heart murmur			19	Back & spine		
10	Abdomen, liver			20	Joints, shoulders,		
	spleen, kidneys				knees & ankles		

Results of Urinalysis:_____

List any current illness(es), medications and explanations of abnormal findings:_____

_____

_____

_____

Capable of participating in sports? ☐ Yes ☐ No ☐ Collision ☐ Contact ☐ Non-Contact

Signature of Health Care Provider:_____

Printed Name of Health Care Provider_____ Date of Examination_____

Name_____ **D.O.B.**_____

IMMUNIZATION RECORD

IV. IMMUNIZATION RECORD

To be completed and signed by your health care provider. ***If submitting titers performed outside of the U.S., please provide a copy of the results.***

REQUIRED VACCINES:

A. TETANUS-DIPTHERIA

1. Tdap, one dose required, if it has been 5 years or more since the last dose of Td ..... ___/___/___ (Mo Day Yr)
2. Td within the last ten years ..... ___/___/___ (Mo Day Yr)

B. M.M.R. (Measles, Mumps, Rubella) (two doses required)

Dose 1 given at 12 months after birth or later and Dose 2 given at least 4 weeks after first dose..... **1** ___/___/___ (Mo Day Yr) **2** ___/___/___ (Mo Day Yr)

OR Measles, Mumps, Rubella Titers (clinical history is not acceptable)

MEASLES (Rubeola) Antibody ___/___/___ (Mo Day Yr) ☐ Immune ☐ Non-immune

RUBELLA (German Measles) Antibody ___/___/___ (Mo Day Yr) ☐ Immune ☐ Non-immune

MUMPS Antibody ___/___/___ (Mo Day Yr) ☐ Immune ☐ Non-immune

C. HEPATITIS B (Three(3) doses of vaccine given as a series of three(3) age-appropriate doses (given at 0, 1-2 months after first dose and 6-12 months after first dose) or a positive Hepatitis B surface antibody meets the requirement.)

1. Dose #1 ___/___/___ (Mo Day Yr) Dose #2 ___/___/___ (Mo Day Yr) Dose #3 ___/___/___ (Mo Day Yr)
2. Hepatitis B surface antibody ___/___/___ (Mo Day Yr) ☐ Immune ☐ Non-immune

D. Varicella

1. History of Disease Yes___ No___ OR
2. Birth in U.S. before 1980 (except students in a health program with patient contact) ☐ Yes ☐ No OR
3. Varicella Antibody ___/___/___ (Mo Day Yr) Result: ☐ Immune ☐ Non-immune OR
4. Immunization
   a. Dose #1 given at age 12 months or later ___/___/___ (Mo Day Yr) b. Dose #2 given at least at least 4 weeks after first dose ___/___/___ (Mo Day Yr)

ALL FULL-TIME STUDENTS 21 YEARS AND YOUNGER, AND ALL STUDENTS (REGARDLESS OF AGE) LIVING IN A DORMITORY OR OTHER CONGREGATE ON-CAMPUS HOUSING:

E. MENINGOCOCCAL (One dose given at age 16 or older or the enclosed waiver may be signed stating that the student has received information regarding meningococcal disease/vaccination and wishes to decline immunization.)

Vaccinated Date ___/___/___ (Mo Day Yr) Type of Vaccine: ☐ Menveo ☐ MenQuadfi

Recommended Vaccine: a clinical discussion with your health care provider is recommended

Meningitis B (Trumenba) 3 doses: Dose #1 ___/___/___ (Mo Day Yr) Dose #2 ___/___/___ (Mo Day Yr) Dose #3 ___/___/___ (Mo Day Yr)

Meningitis B (Bexsero) 2 doses: Dose #1 ___/___/___ (Mo Day Yr) Does #2 ___/___/___ (Mo Day Yr)

HEALTH CARE PROVIDER

Name: _____ Address:_____

Signature:_____ Phone: _____

Please turn to the next page for further immunization record information.

V. TUBERCULOSIS SCREENING **See enclosed TUBERCULOSIS RISK QUESTIONNAIRE**

Must be completed by all students and returned with **HEALTH & IMMUNIZATION** form.

HEALTH INSURANCE — Please attach copy of Health Insurance Card

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MEDICAL TREATMENT RELEASE
FOR STUDENTS UNDER 18 YEARS

PARENTAL PERMISSION

In the event that medical treatment is found to be necessary, I hereby authorize the WSU physician or Nurse Practitioner to render medical treatment to my minor.

If in treatment of a condition, in the exercise of professional judgment, hospitalization is deemed necessary, I hereby consent to hospital care encompassing routine diagnostic procedure, medical treatment, and surgery which may involve the administration of anesthesia.

_____ _____

Date *Parent or Guardian's Signature*

TUBERCULOSIS RISK QUESTIONNAIRE

WORCESTER STATE UNIVERSITY

Mail completed form to:
Worcester State University
Student Health Services
486 Chandler Street
Worcester, MA 01602

Phone: 508-929-8875
Fax: 508-929-8075
Email: health_services@worcester.edu

Must be completed by all students and returned with the **Health & Immunization** form.

Name: _____ Birth Country: _____

Student Signature: _____ Date Completed: _____ Birth Date: _____/_____/_____
Mo Day Year

Please check your answers to all questions

1. Have you ever had a positive tuberculosis (TB) test (if yes, please continue onto Section B): ☐ Yes ☐ No
2. Do you have any symptoms of active tuberculosis:
   - Cough greater than 8 weeks ☐ Yes ☐ No
   - Cough with bloody sputum ☐ Yes ☐ No
   - Unexplained fatigue ☐ Yes ☐ No
   - Unexplained weight loss ☐ Yes ☐ No
   - Night sweats ☐ Yes ☐ No
   - Unexplained fever of 100 degrees F for over 2 weeks ☐ Yes ☐ No
3. To the best of your knowledge, have you had close contact with anyone who was sick with TB: ☐ Yes ☐ No
4. Were you born in one of the countries listed below: ☐ Yes ☐ No
5. Have you ever traveled or lived for more than 1 month in any of the countries listed below: ☐ Yes ☐ No
6. Have you ever lived, worked or volunteered in a nursing home, homeless shelter, hospital, or correctional facility: ☐ Yes ☐ No
7. Do you have a history of immunosuppression (i.e. HIV infection, organ transplant recipient), treated with a TNF-alpha antagonist (Humira, Enbrel), steroid use (>15mg/day x 1 month) or other immunosuppressive medication: ☐ Yes ☐ No

High Risk: If the answer to questions **2, 3, 4, 5, 6 or 7 are "Yes", you are REQUIRED** to have a tuberculin skin test or blood test to check for latent tuberculosis infection. See page 2 for required documentation. **Test must be completed in the U.S.**

Low Risk: If the answer to all the above were **"No"**, no further testing or further action is required.

List of countries for question 4:

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Burkina Faso
Burundi
Caho Verde
Cambodia
Cameroon
Central African Republic
Chad
China
Colombia
Comoros
Congo
Cote d'Ivoire
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Korea
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mexico
Micronesia (Federated States of)
Mongolia
Moldova
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Qatar
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
Thailand
Tanzania
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2020. Countries with incidence rates of 20 cases per 100,000 population. For future updates, refer to http://apps.who.int/ghodata.

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MEDICAL EVALUATION FOR LATENT TUBERCULOSIS INFECTION

(To be completed and signed by a healthcare provider if answered yes to questions 2, 3, 4, 5, 6 or 7)

Student's Name: _____ Birth Date: _____/_____/_____
Mo Day Year

Please note: If patient has had a POSITIVE TUBERCULIN SKIN TEST in the past, the test should not be repeated. **Go to Section B** below.

A. TUBERCULIN TESTING (MANTOUX/PPD OR INTEFERON GAMMA RELEASE ASSAY (IGRA)) **(Test must be completed in the U.S.)**

1.Tuberculin Skin Test—Please note: skin test must be read by a healthcare provider 48 – 72 hours after administration. If no Induration, mark "0".

Date administered: _____/_____/_____ **Date test read:** _____/_____/_____
Mo Day Year Mo Day Year

Result: _____ mm of induration

Interpretation of Tuberculin Skin Test: (Please use table below and check response) ☐ Negative ☐ Positive

Risk Factor	**Positive Result**
Close contact with a case of TB	5 mm or more
Born in a country with a high rate of TB	10 mm or more
Traveled / lived for 1 + months in a country with high TB rates	10 mm or more
No risk factors (test not recommended)	15 mm or more

OR

2. Interferon Gamma Release Assay (IGRA)

Method used: (please check) ☐ QFT – G ☐ Tspot Date obtained: _____/_____/_____
Mo Day Year

Result: (please check appropriate response) ☐ Negative ☐ Positive ☐ Indeterminate/Borderline (requires repeat test)

B. POSITIVE SKIN TEST OR POSITIVE IGRA REQUIRES A CHEST XRAY

1. Date of POSITIVE test: _____/_____/_____ **Testing method:** (please check) ☐ Skin test ☐ IGRA
Mo Day Year

2. Chest X- Ray: (please check) ☐ Normal ☐ Abnormal **Please attach a copy of the report**

3. Treatment: (please check) ☐ Yes ☐ No

Medications, Dates:_____

Healthcare Provider Signature_____ Date _____/_____/_____
Mo Day Year