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

2015-2016 Health Background Form

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

Birthdate: __________/________/_________ Academic Program/Major: ____________________________

Preferred phone #: ____________________________

Emergency contact name & phone #: ____________________________

Part 1  Consent of Parent or Guardian for Treatment of Those Under 18 Years of Age

To be completed if the student is under 18 years of age at the time of arrival on campus even if student will turn 18 during the academic year.

Signature of Parent/Guardian indicates that UB Student Health Services has permission to treat your child. This includes care & treatment by medical providers at any outside health care facility if deemed necessary by UB Student Health Services.

Parent/Guardian Signature ____________________________ Date __________

Part 2  HEALTH HISTORY

1. Drug Allergies: ____________________________

2. Current Medications & doses: ____________________________

3. Medical/Psychological conditions: ____________________________

Part 3  IMMUNIZATION RECORDS

Must be completed and signed by health care provider or attach immunization records from previous school, health care provider or government agency.

MMR (Measles, Mumps, Rubella)  REQUIRED

As mandated by New York State Public Health Law §2165, proof is required if born on or after January 1, 1957.

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>Vaccine Date (Month/Day/Year)</th>
<th>Or Serology Results/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 MMR's</td>
<td>#1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>#2</td>
<td></td>
</tr>
<tr>
<td>2 MEASLES</td>
<td>#1</td>
<td>Attach lab results &amp;/or note if immune</td>
</tr>
<tr>
<td></td>
<td>#2</td>
<td></td>
</tr>
<tr>
<td>1 MUMPS</td>
<td></td>
<td>Attach lab results &amp;/or note if immune</td>
</tr>
<tr>
<td>1 RUBELLA</td>
<td></td>
<td>Attach lab results &amp;/or note if immune</td>
</tr>
</tbody>
</table>

MENINGITIS INFORMATION FORM  REQUIRED

New York State Public Health Law §2167 requires our students to learn about Meningitis and be aware of the availability of the meningitis vaccine (available at a cost from your health care provider or from Student Health Services). While you are not required to receive this vaccine, we strongly urge you to read the full information regarding meningitis at: www.health.buffalo.edu/immunization and to consider immunization.

Mark one of the statements below and provide your signature:

☐ I have received the immunization for meningitis within the past 10 years.
  Date received: ____________________________

☐ I acknowledge the risks associated with meningitis and refuse immunization.
  Signature of student if 18 years of age or older; Date __________
  signature of parent/guardian if student is under 18 years of age

RECOMMENDED VACCINES

Students in health-related profession programs are required to provide proof of PPD (see Part 5), Tetanus (within 10 years), Hepatitis B series, and Varicella vaccine or history of disease. Vaccines listed below are not required for students in other academic programs, but they are recommended.

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>Vaccine Date(s) (Month/Day/Year)</th>
</tr>
</thead>
<tbody>
<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>Circle: Gardasil Gardasil 9 Cervarix</td>
<td></td>
</tr>
<tr>
<td>Meningitis</td>
<td>Meningitis Serogroup B #1 #2 #3</td>
</tr>
<tr>
<td>Meningitis</td>
<td>Circle: Td or Tdap</td>
</tr>
<tr>
<td>Varicella</td>
<td>#1 #2</td>
</tr>
<tr>
<td>Or year of chicken pox</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

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 4 MANDATORY TUBERCULOSIS SCREENING FORM REQUIRED

**Sections A and B are REQUIRED for ALL students**

#### SECTION A: History of Tuberculosis (TB)?

1. Have you ever been sick with tuberculosis?  
   - YES □ NO □

2. Have you ever had a positive PPD, TB Quantiferon test, or T-SPOT?  
   - YES □ NO □

#### SECTION B: At Risk for Tuberculosis (TB)?

1. Are you currently in a health-related academic program/major?  
   - 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? __________________________

   Reason (please circle) Born there Tourist Work School Other __________________________

3. Have you had HIV infection, AIDS, diabetes, leukemia, lymphoma or a chronic immune disorder?  
   - YES □ NO □

4. 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 _______________ Date read _______________ mm induration _______________

QuantIFERON-TB Gold or T-SPOT: Result Date _______________ Result (Circle & attach lab report): Positive □ Negative □ Equivocal □

Date of chest x-ray _______________ Result _______________

If positive PPD or positive TB lab result, did the student take INH or other TB medication(s)?  
   - YES □ NO □

If yes, name & dose of medication(s): __________________________

Start Date of Treatment: _______________ End Date of Treatment: _______________

**PROVIDER INFORMATION REQUIRED**

Signature/Stamp of health care provider __________________________ Phone number of practice __________________________ Date _______________

**Part 5 PHYSICAL EXAMINATION**

*Only REQUIRED for 1st Year Dental and 3rd Year Nursing students. Must be completed and signed by a health care 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 _______________