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

2016-2017 Health Background Form  
University at Buffalo Student Health Services  
Michael Hall, 3435 Main Street, Buffalo, NY 14214-8003  
Phone: 716-829-3316  Fax: 716-829-2564

Name (please print): ____________________________  UB Person #: ______________________

Last   First    MI

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 (combo measles, mumps &amp; rubella vaccine) 1st dose after 1st birthday; 2nd dose at least 28 days later. OR list individual vaccines below</td>
<td>#1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>#2</td>
<td></td>
</tr>
<tr>
<td>2 MEASLES 1st dose after 1st birthday; 2nd dose at least 28 days later</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 after 1st birthday</td>
<td></td>
<td>Attach lab results &amp;/or note if immune</td>
</tr>
<tr>
<td>1 RUBELLA after 1st birthday</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 Circle: Gardasil, Gardasil 9, Cervarix</td>
</tr>
<tr>
<td>Meningitis</td>
<td>#1 #2 #3</td>
</tr>
<tr>
<td>Meningitis Serogroup B</td>
<td>#1 #2 #3</td>
</tr>
<tr>
<td>Tetanus/ Diphtheria</td>
<td>Circle Td or Tdap</td>
</tr>
<tr>
<td>Varicella</td>
<td>#1 #2</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.

<table>
<thead>
<tr>
<th>Test</th>
<th>Date Placed</th>
<th>Date Read</th>
<th>mm Induration</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Test</th>
<th>Date</th>
<th>Result (attach lab report)</th>
</tr>
</thead>
<tbody>
<tr>
<td>QuantIFERON-TB Gold or T-SPOT</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chest x-ray</th>
<th>Date</th>
<th>Result</th>
</tr>
</thead>
</table>

If negative CXR and positive PPD/Lab Result, did the student complete a course of INH or other TB Treatment?  
   - YES □  NO □

If yes, name of medication: ___________________________

Date Range of Treatment: ___________________________ How many months did student take medication? __________________ (# of months)

#### 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 __________________________