Health Services Immunization and Health Information

Your complete record for required vaccines (Part II) must be on file in our Health Center before the start of classes or you will be MEDICALLY WITHDRAWN FROM CLASSES per NYS Public Health Laws 2165 and 2167. Please contact Health Services with any questions. (607-844-8222 x4487) or refer to our website for further information: http://www.tc3.edu/student/health_immunizations.asp

Part I: TO BE COMPLETED BY STUDENT

Name _____ _____
First Name Middle Name

_____
Last Name

Address _____
Street City State Zip

Date of Entry ____/_____ Date of Birth ____/____/_____ School ID# _____
M Y M D Y

PART II: TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

All information must be in English.

REQUIRED IMMUNIZATIONS

A. MMR (MEASLES, MUMPS, RUBELLA)

(Two doses required at least 28 days apart for students born after 1956.)

1. Dose 1 given at age 12 months or later . ..... #1 ____/____/_____
M D Y
2. Dose 2 given at least 28 days after first dose . ..... #2 ____/____/_____
M D Y

OR

Positive antibodies for Measles, Mumps, and Rubella. ***ATTACH COPY OF LAB RESULTS***

B. MENINGOCOCCAL QUADRIVALENT

(A, C, Y, W-135) One dose within the last 5 years or a completed 2-dose series.

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).

   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____
   M D Y M D Y

2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available).

   Date ____/____/_____
   M D Y

3. Declination: (acceptable)
   If the student/parent declines the meningococcal vaccine, a signature is needed:

I have decided to decline the Meningitis vaccine by signing below. I have read, or have had explained to me the information regarding meningococcal meningitis disease. ***I understand the risks of not receiving the vaccine.***

Student signature: _____ Date ____/____/_____
(Parent or guardian signature if student under 18 years of age) M D Y

Health Services Immunization and Health Information

Part II: TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER (continued)

RECOMMENDED IMMUNIZATIONS

C. TETANUS, DIPHTHERIA, PERTUSSIS

1. Date of last dose in series: ____/____/_____
   M D Y

2. Date of most recent booster dose: ____/____/_____ Type of booster: Td _____ Tdap _____
   M D Y *Tdap booster recommended for ages 11-64 unless contraindicated*

D. VARICELLA (A positive varicella antibody or two doses of varicella vaccine)

1. Positive varicella antibody. **ATTACH COPY of LAB RESULTS**

2. Immunization

   a. Dose #1 . ..... #1 ____/____/_____
   M D Y

   b. Dose #2 given at least 12 weeks after first dose ages 1–12 years. ..... #2 ____/____/_____
   and at least 4 weeks after first dose if age 13 years or older. M D Y

E. POLIO

(Primary series, doses at least 28 days apart. Three primary series are acceptable. See ACIP website for details.)

1. OPV alone (oral Sabin three doses): #1 ____/____/_____ #2 ____/____/_____ #3 ____/____/_____
   M D Y M D Y M D Y

2. IPV/OPV sequential: IPV #1 ____/____/_____ IPV #2 ____/____/_____ OPV #3 ____/____/_____ OPV #4 ____/____/_____
   M D Y M D Y M D Y M D Y

3. IPV alone (injected Salk four doses): #1 ____/____/_____ #2 ____/____/_____ #3 ____/____/_____ #4 ____/____/_____
   M D Y M D Y M D Y M D Y

HEALTH CARE PROVIDER

Name _____ Signature _____

Address _____ Phone (_____)_____

Health Services Immunization and Health Information

PART III. TUBERCULOSIS (TB) SCREENING/TESTING[1]

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? ❑ Yes ❑ No

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? ❑ Yes ❑ No
(If yes, please CIRCLE the country, below)

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2014. Countries and territories with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.

Have you had frequent or prolonged visits* to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, CHECK the countries or territories, above) ❑ Yes ❑ No

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ❑ Yes ❑ No

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? ❑ Yes ❑ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? ❑ Yes ❑ No

If the answer is YES to any of the above questions, Tompkins Cortland Community College requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester. **THIS MUST BE DONE BY YOUR HEALTH CARE PROVIDER.**

If the answer to all of the above questions is NO, no further testing or further action is required.

* *The significance of the travel exposure should be discussed with a health care provider and evaluated.*

[1]The American College Health Association has published guidelines on "Tuberculosis Screening and Targeted Testing of College and University Students." To obtain the guidelines, visit http://www.acha.org/Guidelines.

Health Services Immunization and Health Information

TUBERCULOSIS (TB) RISK ASSESSMENT (to be completed by **health care provider)**

Clinicians should review and verify the information above. Persons answering YES to any of the questions in Part M are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below) **Yes _____ No _____**

History of BCG vaccination? (If yes, consider IGRA if possible.) **Yes _____ No _____**

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1. TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes _____ No _____ *If No, proceed to 2 or 3*

If yes, check below:

- ❑ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- ❑ Coughing up blood (hemoptysis)
- ❑ Chest pain
- ❑ Loss of appetite
- ❑ Unexplained weight loss
- ❑ Night sweats
- ❑ Fever

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ____/____/____ (M D Y) Date Read: ____/____/____ (M D Y)

Result: _____ mm of induration **Interpretation: positive____ negative____

Date Given: ____/____/____ (M D Y) Date Read: ____/____/____ (M D Y)

Result: _____ mm of induration **Interpretation: positive____ negative____

****Interpretation guidelines**

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

>10 mm is positive:

- recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

>15 mm is positive:

- persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

** The significance of the travel exposure should be discussed with a health care provider and evaluated.*

3. Interferon Gamma Release Assay (IGRA) (OPTIONAL)

Date Obtained: ____/____/____ (M D Y) (specify method) QFT-GIT T-Spot other_____

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

Date Obtained: ____/____/____ (M D Y) (specify method) QFT-GIT T-Spot other_____

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

Health Services Immunization and Health Information

4. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: ____/____/____ Result: normal____ abnormal_____
M D Y

Management of Positive TST or IGRA

All students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- ❑ Infected with HIV
- ❑ Recently infected with *M. tuberculosis* (within the past 2 years)
- ❑ History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- ❑ Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- ❑ Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- ❑ Have had a gastrectomy or jejunoileal bypass
- ❑ Weigh less than 90% of their ideal body weight
- ❑ Cigarette smokers and persons who abuse drugs and/or alcohol

••Populations defined locally as having an increased incidence of disease due to *M. tuberculosis,* including medically underserved, low-income populations

_____ Student agrees to receive treatment

_____ Student declines treatment at this time

HEALTH CARE PROVIDER

Name _____ Signature _____

Address _____ Phone (_____)_____

Health Services Immunization and Health Information

PART IV: Physical Exam (Highly Recommended) Must be completed and signed by your health care provider.
Students with known health concerns are encouraged to consult with their health care providers before coming to Tompkins Cortland Community College.

Patient Name: _____ Date of Exam _ _ / _ _ / _ _ _ _
Last First Middle mm/ dd / yyyy

Date of Birth: _ _/ _ _/ _ _ _ _ Gender: Male ____ Female _____
m m / d d / y y y y

Blood Pressure: _____ Pulse: _____ Height: _____ Weight: _____

Vision: O.S. _____ O.D. _____ With correction? _____Yes _____ No

Clinical Evaluation

Check each item in proper column. Check Normal or Abnormal or write N.E. if not evaluated.

	Normal	Abnormal	Comments
1. Head, ears, eyes, nose, neck			
2. Heart			
3. Lungs			
4. Abdomen			
5. Genitourinary			
6. Musculoskeletal			
7. Neurological			
8. Mental health			

Will any accommodations be needed while attending college?

To the best of your knowledge, this student is physically and emotionally ready for college life: _____Yes _____No

Health Care Provider Signature: _____

Health Care Provider Name (PRINT): _____

Contact Information: _____