

## STUDENT MEDICAL REPORT

### For Graduate and Part-time Undergraduate Students

The State of Connecticut General Statutes HB 6423 and Fairfield University require each full-time or matriculating student to provide proof of immunity or screening against measles, mumps, rubella, varicella, meningitis and tuberculosis. Matriculating students are defined as those enrolled in a degree seeking program. This includes both undergraduate and graduate students.

#### The following are MANDATORY:

**Proof of immunity to Measles, Mumps and Rubella (MMR)** (Students born before Jan. 1, 1957 are exempt)—You must provide proof of one of the following:

Two MMR immunizations (one on or after your first birthday and after Jan. 1, 1969 AND one at least 28 days later and after Jan. 1, 1980)\*, OR

Documentation of positive MMR titer (blood test), OR

Documentation of date of MMR disease by your health care provider

**Proof of immunity to Varicella (Chickenpox)** (Students born in the U.S.A. before Jan. 1, 1980 are exempt)—You must provide proof of one of the following:

Two varicella immunizations (one on or after your first birthday and one at least 28 days later)\*, OR

Documentation of positive Varicella titer (blood test), OR

Documentation of date of varicella disease by your health care provider

**\* HealthCare Providers please note: The recommended minimum interval between doses of two live injectable vaccines is 28 days if the doses are not given simultaneously.**

**Proof of Immunity to Meningitis** (Required for students living on campus only)—You must provide proof of having received a quadrivalent meningococcal conjugate vaccine not more than five (5) years before enrollment. Examples of quadrivalent meningococcal conjugate vaccine include *Menactra*® or *Menveo*®.

**Tuberculosis (TB) Screening** ALL students are required to complete a series of TB risk assessment questions. Students determined to be at high risk for TB need TB testing as outlined on the Medical Report Form.

**Hepatitis B immunization is recommended.** (This is not a requirement.) A Hepatitis B Fact Sheet is available on the Student Health Center web page.

**Serogroup B Meningococcal Vaccine is recommended.** (This is not a requirement.) Teens and young adults (16 through 23 year olds) may also be vaccinated with a serogroup B meningococcal vaccine (*Bexsero*® or *Trumenba*®) to provide protection against most strains of serogroup B meningococcal disease. Two or three doses are needed depending on the brand.

**COVID-19 Vaccine is strongly recommended.** (This is not a requirement.)

IT IS MANDATORY THAT YOU DOCUMENT THE REQUIREMENTS USING THE STUDENT MEDICAL REPORT FORM (see below) BEFORE YOU MAY REGISTER FOR CLASSES AT FAIRFIELD UNIVERSITY.

#### IMMUNIZATION EXEMPTIONS:

Students born prior to January 1, 1957 are exempted by age to the measles, mumps and rubella requirement.

Students **born in the U.S.A.** before January 1, 1980 are exempted by age to the varicella requirement.

The university will only permit vaccination waivers for medical reasons. A signed statement indicating the specific medical contraindication from your health care provider is required for medical exemption. Exemption for medical reasons subjects the individual to exclusion from campus in the event of an outbreak of a disease for which immunizations are required.

The Immunization Exemption Form is available at [www.fairfield.edu/immunization](http://www.fairfield.edu/immunization).

Mandatory immunization requirements are strictly enforced. Please consult your private health care provider to obtain necessary vaccinations. The Student Health Center is not able to offer all vaccinations.

Please Note: Students enrolled in the Fairfield University School of Nursing will be notified of additional specialized immunization requirements and documentation procedures.



This form is to be used by the following student groups (Please indicate your group or program):

- Graduate Student, Degree Seeking Part-time Undergraduate Student, RN to BSN Program, Second Degree Nursing Program

Instructions

Once completed, please upload this entire form to our secure patient portal at: www.fairfield.edu/immunization. Alternatively, this form may be mailed to: Fairfield University Student Health Center 1073 N. Benson Road Fairfield, CT 06824-5195. Please keep a copy for your personal records.

This page to be completed by the student (required).

ID \_\_\_\_\_

Name \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ # Street \_\_\_\_\_ Home Phone No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone No. \_\_\_\_\_

Email Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Relationship to you \_\_\_\_\_

School you are enrolling in:

- Charles F. Dolan School of Business, College of Arts and Sciences, Graduate School of Education and Allied Professions, School of Engineering, School of Nursing, (Includes Second Degree Nursing Program and RN to BSN Program)

INSTRUCTIONS:

The student and his/her Health Care Provider should complete this Medical Report as directed. All forms must be completed in English. Dates should be listed as Month/Date/Year. Completed forms should be mailed to the Student Health Center at the above address. Please keep a copy of the completed form for your personal records.

All information contained on this form is privileged and confidential and may not be copied or distributed without the permission of the student.

The following questions are required to determine if any immunization/immunity exemptions apply:

Your date of birth is \_\_\_\_\_

Will you be living in on-campus or University owned housing? YES NO

Were you born in the United States of America? YES NO

If NO, please list country of birth \_\_\_\_\_

Is your undergraduate degree from Fairfield University? YES NO

*This page to be completed by your Healthcare Provider.*

**MMR (Measles, Mumps and Rubella) Immunizations/Immunity (required by state law for students born 1/1/57 or after):**

MMR Vaccine Date#1 \_\_\_\_/\_\_\_\_/\_\_\_\_ MMR Vaccine Date#2 \_\_\_\_/\_\_\_\_/\_\_\_\_

OR attach copy of MMR titer results OR attach certificate of disease from a physician

**Varicella (Chickenpox) Immunizations/Immunity (required by state law. Students born in the USA before 1/1/80 are exempt from this requirement):**

Vaccine Date#1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Vaccine Date#2 \_\_\_\_/\_\_\_\_/\_\_\_\_

OR attach copy of Varicella titer results OR Date of disease \_\_\_\_/\_\_\_\_/\_\_\_\_

**Quadrivalent Meningococcal Immunization (required by state law for students living on campus only): Must be within the 5 years prior to starting classes, (minimum 1 dose required):**

Vaccine Date #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Vaccine Date #2 \_\_\_\_/\_\_\_\_/\_\_\_\_

**Recommended Immunizations (not required):**

Tetanus Vaccine Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Td  Tdap  Updated within 10 years

Hepatitis B Series Date#1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Date#2 \_\_\_\_/\_\_\_\_/\_\_\_\_ Date#3 \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>Serogroup B Meningococcal Vaccine (students ages 16-23)</b>		Recommended, not required		
<i>Bexsero</i> <sup>®</sup>		<b>OR</b>	<i>Trumenba</i> <sup>®</sup>	
Date#1 ____/____/____	#2 ____/____/____	Date#1 ____/____/____	#2 ____/____/____	#3 ____/____/____

<b>COVID-19 Vaccine</b>	Recommended, not required
<b>Brand:</b> _____	Vaccine Date#1 ____/____/____ Vaccine Date#2 ____/____/____
Please attach a copy of your COVID-19 vaccine card or certificate	

**Tuberculosis (TB) Screening (required):**

**PART I:** To be completed by student and reviewed by health care provider:

- Have you ever had a positive tuberculosis skin or blood test in the past? Yes  No
- Have you ever had close contact with persons known or suspected to have active TB disease? Yes  No
- Were you born in a country that has a high incidence of active TB disease (see Appendix A, page 4)? Yes  No
- Have you had frequent or prolonged visits\* to one or more of the countries listed in Appendix A? Yes  No
- Have you been a resident, employee, or volunteer in a high risk congregate setting (e.g. correctional facilities, homeless shelters, high risk health care facilities)? Yes  No
- Do you have a health condition (listed in Appendix B) which suppresses your immune system? Yes  No

**If the answer is YES to any of the above questions, TB testing (as outlined in Part II) is required. Continue to Part II.**

If the answer is **NO** to all of the above questions no further testing or action is required. You may stop here.

Signature of Health Care Provider \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

Address \_\_\_\_\_ Phone No. \_\_\_\_\_

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

Reviewed by SHC RN: Initials \_\_\_\_ Date \_\_\_\_

**Part II Tuberculosis (TB) Screening:**

Clinical Assessment by the Health Care Provider: Clinicians should review and verify the information in Part I. Only persons answering YES to any of the questions in Part I are candidates for either Mantoux Tuberculin Skin Test or Interferon Gamma Release Assay (IGRA), (unless a previous positive test has been documented).

Does this student have a history of positive TB skin test or IGRA blood test? Yes  No

(If YES, document below)

Does this student have a history of BCG vaccination? (If yes, consider IGRA, if possible) Yes  No

(A history of BCG vaccination does not preclude testing of a member of a high risk group.)

1. Does the student have signs and symptoms of active tuberculosis disease? Yes  No

If NO (and student is high risk for TB), proceed to #2 or #3.

If YES, proceed with evaluation to exclude active TB disease including TST, chest X-ray and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)

TST result should be recorded in mm of induration, transverse diameter, if no induration, write "0".

See Appendix C for interpretation guidelines.

Date given: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date read: \_\_\_\_/\_\_\_\_/\_\_\_\_

Result \_\_\_\_ mm induration

Interpretation: Positive

Negative

3. Interferon Gamma Release Assay (IGRA)

Date obtained: \_\_\_\_/\_\_\_\_/\_\_\_\_

Result: Positive

Negative

4. Chest X-Ray (Required if TST or IGRA is positive):

Date of Chest X-Ray: \_\_\_\_/\_\_\_\_/\_\_\_\_

Results: Normal

Abnormal

(Report to Health Dept. if abnormal chest X-Ray)

**PART III 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.

Student agrees to receive treatment.

Student declines treatment at this time.

This student has completed TB treatment  List medication(s) and dates of treatment:

Medication(s): \_\_\_\_\_ Dates of treatment: \_\_\_\_\_

Signature of Health Care Provider

Date

Print Name

Address

Phone No.

**Appendix A: List of high<sup>1</sup> risk TB countries. Circle country or countries identified in part I of TB screening:**

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

**Appendix B: Health Conditions causing immune suppression:**

- HIV/AIDS
- Organ Transplant recipient
- Immunosuppressed persons:  
e.g. taking > 15mg/day of prednisone for >1 month; immunosuppressive therapy (TNF- $\alpha$  antagonist, cancer chemotherapy)

**Appendix C: TST 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 >1month.)
- 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 jejunioileal 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.

<sup>1</sup> Incidence rate of  $\geq 20/100,000$   
Data available at: [www.who.int/tb/country/data/profiles/en/](http://www.who.int/tb/country/data/profiles/en/)