



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 _____ Student Cell Phone No. _____

Emergency Contacts

Father's Name or Guardian's _____ Home Phone _____ Cell Phone _____ Work Phone _____ Occupation _____

Mother's Name or Guardian's _____ Home Phone _____ Cell Phone _____ Work Phone _____ Occupation _____

CONSENT

I HEREBY GIVE CONSENT FOR MY (MINOR CHILD) (SELF) TO RECEIVE ROUTINE CARE THROUGH THE FAIRFIELD UNIVERSITY STUDENT HEALTH CENTER.

Signature of Parent or Guardian _____ Date _____

Signature of Student _____ Date _____

Student Health Insurance & Waiver

Fairfield University requires all full-time undergraduate students to subscribe to a health insurance policy. Students are automatically enrolled and billed for the University-sponsored plan. Students who have comparable health insurance coverage and do not wish to be enrolled in the University-sponsored plan must complete an online waiver to provide proof of coverage. For more information go to www.fairfield.edu/healthcenter

PERSONAL HEALTH HISTORY

MEDICAL OR HEALTH CONCERNS — Please check conditions/diseases you have had. If NONE apply, check this box.

Table with 4 columns of medical conditions: Absent/Irregular Periods, Acne, Anemia, Anxiety, Arthritis, Asthma, Attention Deficit Disorder, Autistic Spectrum Disorder, Back Problem, Bipolar Disorder, Bowel Problem, Cancer, Celiac Disease, Depression, Diabetes Mellitus, Eating Disorder, Fainting (Frequent), Fracture (Specify), Gastroesophageal Reflux Disease, Head Injury/Concussion, Hearing Impairment, Heart Problem, High Blood Pressure, H.I.V., Kidney Disease, Liver Disease, Migraine Headaches, Mononucleosis, Obsessive Compulsive Disorder, Painful Periods, Pneumonia, Polycystic Ovarian Syndrome, Pregnancy, Seizure Disorder/Epilepsy, Sexually Transmitted Disease, Skin Problem, Substance Use Disorder, Substance Use Disorder: In Recovery, Surgery (Specify), Thyroid Disease, Urinary Tract Infection (Recurrent), Visual Impairment, COVID-19, Date:

Please explain any checked boxes: _____

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

ALLERGIES: YES NO

Drug Allergy (specify): _____ Type of reaction: _____

Food* (specify): _____ Type of reaction: _____

Environmental/Other Allergies (specify): _____ Type of reaction: _____

* Students with food allergies are directed to www.fairfield.edu/foodallergies.

This web-page has important information and additional forms which need to be completed.

MEDICATIONS:

Are you currently taking medication? (Include over the counter, vitamins/supplements, birth control pills.)

Please list below:

Medication Name	Dose	Frequency

Chronic or long-term, ongoing medical condition? (**Please have physician write a medical summary and attach to this form.**)

List date(s) and reason(s) for any hospitalizations.

Have you had emotional or psychological problems? Describe type of treatment (e.g., hospitalizations, psychotherapy and/or medications.)

Any additional health information you would like to add:

FAMILY HISTORY

Name	Age	Medical Conditions/ Health Concerns	Cause of Death	Age at Death/ Year of Death
Father				
Mother				
Siblings				
Children				

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

Name _____

Date of Birth _____

This page to be completed by your Healthcare Provider (recommended but not required).

PHYSICAL EXAMINATION

Date of Physical Exam _____

Height _____ Weight _____ BP _____ / _____ Pulse _____

Vision: Rt 20/_____ Lt 20/ _____ Glasses: Rt 20/_____ Lt 20/ _____

Hearing: Rt _____ Lt _____

General Development

	Normal	Abnormal	Explanation
Skin			
Eyes			
Ears			
Nose			
Throat			
Teeth			
Neck			
Thyroid			
Chest			
Heart			
Abdomen			
External Genitalia			
Hernia			
Pelvic			
Rectal			
Neurological			
Musculoskeletal			

Urinalysis: Date _____ Results _____

Hgb or Hct _____ Date _____

Allergies _____

Medications _____

Additional comments and recommendations: _____

Signature of Health Care Provider _____

Date _____

Print Name _____

Office Address _____

Office Phone No. _____

This page to be completed by your Healthcare Provider.

MMR (Measles, Mumps and Rubella) Immunizations/Immunity (required by state law):

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):

Vaccine Date#1 ____/____/____ Vaccine Date#2 ____/____/____
OR attach copy of Varicella titer results OR Date of disease ____/____/____

Quadrivalent Meningococcal Conjugate Immunization (required by state law): Must be within the 5 years prior to starting classes

Menactra® Menveo® (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 ____/____/____

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

COVID-19 Vaccine Recommended, not required
Brand: _____ 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:

Country of Birth: _____

- 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 6)? 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 high¹ 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	
Belize	Djibouti	Lao People's	Pakistan	Thailand
Benin	Dominican Republic	Democratic Republic	Palau	Timor-Leste
Bhutan	Ecuador	Latvia	Panama	Togo
Bolivia (Plurinational	El Salvador	Lesotho	Papua New Guinea	Tunisia
State of)	Equatorial Guinea	Liberia	Paraguay	Turkmenistan
Bosnia and	Eritrea	Libya	Peru	Tuvalu
Herzegovina	eSwatini	Lithuania	Philippines	Uganda
Botswana	Ethiopia	Madagascar	Portugal	Ukraine
Brazil	Fiji	Malawi	Qatar	Uruguay
Brunei Darussalam	French-Polynesia	Malaysia	Republic of Korea	Uzbekistan
Bulgaria	Gabon	Maldives	Republic of Moldova	Vanuatu
Burkina Faso	Gambia	Mali	Romania	Venezuela (Bolivarian
Burundi	Georgia	Marshall Islands	Russian Federation	Republic of)
Cabo Verde	Ghana	Mauritania	Rwanda	Viet Nam
Cambodia	Greenland	Mexico	Sao Tome and Principe	Yemen
Cameroon	Guam	Micronesia (Federated	Senegal	Zambia
Central African	Guatemala	States of)	Sierra Leone	Zimbabwe
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- α 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.

¹ Incidence rate of $\geq 20/100,000$
Data available at: www.who.int/tb/country/data/profiles/en/