STUDENT MEDICAL REPORT
For Graduate and Part-time Undergraduate Students

The State of Connecticut General Statutes Section 10a - 155 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.

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 religious or medical reasons. A signed Immunization Exemption Form indicating the specific medical contraindication from your health care provider is required for medical exemption. A signed Immunization Exemption Form stating religious objections to immunization must be submitted in order to obtain a religious exemption. The Immunization Exemption Form is available on the Student Health Center web page.

Exemption for either medical or religious reasons subjects the individual to exclusion from campus in the event of an outbreak of a disease for which immunizations are required.

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

This medical report in its entirety is to be mailed to: Student Health Center, Dolan Hall, Fairfield University, 1073 North 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 __________________________ Home Phone No. __________________________

# Street __________________________ Cell Phone No. __________________________

City __________ State __________ Zip __________________________

E-mail Address __________________________

Emergency Contact Home Phone __________ Cell Phone __________ Relationship to you __________________________

School you are enrolling in:

- Charles F. Dolan School of Business
- School of Engineering
- College of Arts and Sciences
- School of Nursing
- Graduate School of Education and Allied Professions (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 □
MMR (Measles, Mumps and Rubella) Immunizations/Immunity (required by state law for students born 1/1/57 or after):

- MMR Vaccine Date#1 _____/_____/_____  OR  attach copy of MMR titer results
- MMR Vaccine Date#2 _____/_____/_____  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 _____/_____/______  OR  attach copy of Varicella titer results
- Vaccine Date#2 _____/_____/______  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 _____/______/______  OR  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_____/_____/_____

<table>
<thead>
<tr>
<th>Serogroup B Meningococcal Vaccine (students ages 16-23)</th>
<th>Recommended, not required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexsero® Date#1_____/<em><strong><strong>/</strong></strong></em> #2 <em><strong><strong>/</strong></strong></em>/_____</td>
<td>OR</td>
</tr>
<tr>
<td>Trumenba® Date#1_____/<em><strong><strong>/</strong></strong></em> #2 <em><strong><strong>/</strong></strong></em>/_____ #3 <em><strong><strong>/</strong></strong></em>/_____</td>
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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 __________________________________________________________ Phone No. _______________________

Address ____________________________________________________________
### Appendix A: List of high risk TB countries. Circle country or countries identified in part I of TB screening:

<table>
<thead>
<tr>
<th>Afghanistan</th>
<th>Comoros</th>
<th>Kazakhstan</th>
<th>Niger</th>
<th>Sudan</th>
</tr>
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<tbody>
<tr>
<td>Albania</td>
<td>Congo</td>
<td>Kenya</td>
<td>Nigeria</td>
<td>Suriname</td>
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<tr>
<td>Algeria</td>
<td>Côte d’Ivoire</td>
<td>Kyrgyzstan</td>
<td>Kuwait</td>
<td>Swaziland</td>
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<tr>
<td>Angola</td>
<td>Democratic People’s Republic of Korea</td>
<td>Lao People’s Democratic Republic</td>
<td>Northern Mariana Islands</td>
<td>Syrian Arab Republic</td>
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<td>Anguilla</td>
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<td>Taiwan</td>
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<tr>
<td>Argentina</td>
<td>Democratic Republic of the Congo</td>
<td>Latvia</td>
<td>Laos</td>
<td>Tajikistan</td>
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<tr>
<td>Armenia</td>
<td>Djibouti</td>
<td>Lesotho</td>
<td>Palau</td>
<td>Thailand</td>
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<tr>
<td>Azerbaijan</td>
<td>Dominican Republic</td>
<td>Liberia</td>
<td>Palau</td>
<td>The former Yugoslav Republic of Macedonia</td>
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<tr>
<td>Bangladesh</td>
<td>Ecuador</td>
<td>Libyan Arab Jamahiriya</td>
<td>Papua New Guinea</td>
<td>Timor-Leste</td>
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<tr>
<td>Belarus</td>
<td>El Salvador</td>
<td>Lithuania</td>
<td>Paraguay</td>
<td>Togo</td>
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<tr>
<td>Belize</td>
<td>Equatorial Guinea</td>
<td>Madagascar</td>
<td>Peru</td>
<td>Trinidad and Tobago</td>
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<td>Benin</td>
<td>Eritrea</td>
<td>Malawi</td>
<td>Philippines</td>
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<td>Bhutan</td>
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<td>Malaysia</td>
<td>Poland</td>
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<td>Bolivia</td>
<td>Ethiopia</td>
<td>Maldives</td>
<td>Portugal</td>
<td>Turkmenistan</td>
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<tr>
<td>(Plurinational State of)</td>
<td></td>
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<td>Qatar</td>
<td>Tuvalu</td>
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<tr>
<td>Bosnia and Herzegovina</td>
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<td>Marshall Islands</td>
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<td>Russian Federation</td>
<td>United Republic of Tanzania</td>
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<td>Brunei Darussalam</td>
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<td>Bulgaria</td>
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<td>Saint Vincent and the Grenadines</td>
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<td>Burkina Faso</td>
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<td>Cambodia</td>
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<td>China, Hong Kong Special Administrative Region</td>
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<td>Nicaragua</td>
<td>Somalia</td>
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<td>China, Macao Special Administrative Region</td>
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<td>North Korea</td>
<td>South Africa</td>
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<td>Colombia</td>
<td>Iraq</td>
<td>North Korea</td>
<td>South Sudan</td>
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<tr>
<td></td>
<td>Japan</td>
<td>North Korea</td>
<td>Sri Lanka</td>
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</table>

### 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
- Immunosuppressed persons: e.g. taking > 15 mg/day of prednisone for > 1 month; immunosuppressive therapy (TNF-α antagonist, cancer chemotherapy)
- Persons with HIV/AIDS

>10 mm is positive:

- Persons born in a high incidence country or who resided in one for a significant* amount of time
- History of illicit drug use
- Mycobacteriology laboratory personnel
- History of resident, worker, or volunteer in high-risk congregate settings
- Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes

>15 mm is positive:

- Persons with no known risk factors for TB disease

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1 Incidence rate of ≥ 20/100,000

Data available at: www.who.int/tb/country/data/profiles/en/