GRADUATE STUDENT MEDICAL REPORT

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 (Chicken Pox) (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

Proof of Immunity to Meningitis (Required for students living on campus only)—You must provide proof of meningococcal immunization having been administered within the 5 years prior to starting classes. A Meningococcal Disease Fact Sheet is available on the Student Health Center web page.

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.

IT IS MANDATORY THAT YOU DOCUMENT THE REQUIREMENTS USING THE GRADUATE 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.
Graduate Student Medical Report

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 ________________________________________________________________
# Street _________________________________________________________________
City __________________ State __________ Zip ________________

Home Phone No. ____________________________ Cell Phone No. ____________________________

E-mail Address __________________________________________________________

Emergency Contact Home Phone Cell Phone Relationship to you

Graduate 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 ____/_____/_____   MMR Vaccine Date#2 _____/_____/_____
OR  attach copy of MMR titer results    OR  attach certificate of disease from a physician

Varicella (Chicken Pox) 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 _____/_____/______

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_____/_____/_____

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  ____________________________________________  Phone No. ______________________

Address  ____________________________________________

________________________________________________________________________________________________________

*The significance of the exposure should be discussed with a health care provider and evaluated.
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 risk TB countries. Circle country or countries identified in part I of TB screening:

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<tr>
<th>Country</th>
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<td>Afghanistan</td>
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<td>Kazakhstan</td>
<td>Niger</td>
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<td>Kenya</td>
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<td>Kiribati</td>
<td>Niue</td>
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<td>Anguilla</td>
<td>Democratic People’s Republic</td>
<td>Kuwait</td>
<td>Northern Mariana Islands</td>
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<td>Republic of Korea</td>
<td>Kyrgyzstan</td>
<td>Pakistan</td>
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<td>Armenia</td>
<td>Democratic Republic of Congo</td>
<td>Lao People’s Democratic</td>
<td>Palau</td>
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<td>Azerbaijan</td>
<td>Dijibouti</td>
<td>Latvia</td>
<td>Panama</td>
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<td>Bahrain</td>
<td>Dominican Republic</td>
<td>Lesotho</td>
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<td>Bangladesh</td>
<td>El Salvador</td>
<td>Libyan Arab Jamahiriya</td>
<td>Peru</td>
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<td>Belarus</td>
<td>Equatorial Guinea</td>
<td>Lithuania</td>
<td>Philippines</td>
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<td>Belize</td>
<td>Estonia</td>
<td>Madagascar</td>
<td>Poland</td>
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<td>Bhutan</td>
<td>Fiji</td>
<td>Malaysia</td>
<td>Qatar</td>
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<td>Bolivia</td>
<td>French Polynesia</td>
<td>Mali</td>
<td>Republic of Korea</td>
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<tr>
<td>Bosnia and Herzegovina</td>
<td>Gabon</td>
<td>Marshall Islands</td>
<td>Romania</td>
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<td>Gambia</td>
<td>Mauritania</td>
<td>Russian Federation</td>
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<td>Brazil</td>
<td>Georgia</td>
<td>Mauritius</td>
<td>Rwanda</td>
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<td>Brunei Darussalam</td>
<td>Ghana</td>
<td>Mexico</td>
<td>Saint Vincent and the</td>
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<td>Guam</td>
<td>Micronesia (Federated States of)</td>
<td>Sao Tome and Principe</td>
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<td>Burkina Faso</td>
<td>Guayam</td>
<td>Mongolia</td>
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<td>Guinea-Bissau</td>
<td>Myanmar (Burma)</td>
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<td>Cape Verde</td>
<td>Haiti</td>
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<td>Indonesia</td>
<td>Nepal</td>
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<td>China, Hong Kong Special</td>
<td>Iran</td>
<td>Netherlands Antilles</td>
<td>South Sudan</td>
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<td>Iraq</td>
<td>New Caledonia</td>
<td>Sri Lanka</td>
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<tr>
<td>China, Macao Special</td>
<td>Japan</td>
<td>Nicaragua</td>
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<td>Administrative Region</td>
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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

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

1 Greater than 20/100,000 population - Estimates can be found at http://apps.who.int/gho/data/view.main.57040ALL?lang=en