

# HEALTH & IMMUNIZATION FORM



**WORCESTER**  
S T A T E  
**UNIVERSITY**

*Mail completed form to:*

**Worcester State University  
Student Health Services  
486 Chandler Street, Worcester, MA 01602**

Phone: 508-929-8875  
Fax: 508-929-8075

**Please check all appropriate boxes:**

Commuter       Campus resident       Freshman       Graduate       Transfer  
 Athlete       IELI       Exchange       Nursing, OT, CD      Status: PT  FT

## I. GENERAL INFORMATION: TO BE COMPLETED BY STUDENT

***This Health Examination Form must be completed in its entirety. Incomplete reports will be returned.***

Name \_\_\_\_\_  
Last First Middle

Birthdate \_\_\_\_\_ Birthplace \_\_\_\_\_  
Month Day Year

Gender Identity \_\_\_\_\_

Permanent Home Address: \_\_\_\_\_  
No. Street  
City State Zip

Home Phone ( ) \_\_\_\_\_ Student's Cell# ( ) \_\_\_\_\_

Parent's Name \_\_\_\_\_ Parent's Name \_\_\_\_\_  
Last First Middle Last First Middle

Home Address \_\_\_\_\_ Home Address \_\_\_\_\_  
No. Street No. Street  
City State Zip City State Zip

Home Phone ( ) \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Business Phone ( ) \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_

### Someone other than parents to be notified in case of emergency (if parents are unavailable):

Name \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_

Address \_\_\_\_\_

Do you have any allergy to medication? Yes \_\_\_\_\_ No \_\_\_\_\_

Please list: \_\_\_\_\_

Do you have any serious medical condition? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

### FOR OFFICE USE ONLY

University Address \_\_\_\_\_

University Telephone # \_\_\_\_\_

**II. MEDICAL HISTORY**

**Please complete this section before going to your physician for examination.**

Have you ever had or have you now a problem with (check at right of each item): (Explain YES answers below)

Check each item:	Yes	No	Yes	No	Yes	No	Yes	No
Head & nervous system			Poor teeth/toothaches		Hepatitis or jaundice		Exposure to DES	
Headaches			Gum Disease		Genitourinary system		Infectious disease	
Fainting			Heart, Lungs		Blood in urine		Mononucleosis	
Severe head injury			High blood pressure		Cystitis		Chicken pox	
Seizures/convulsions			Heart murmur		Kidney infection/disease		TB or positive skin test	
Dizzy spells			Heart trouble		Menstrual disorder		Past illnesses	
Insomnia			Palpitations		Bones, joints		Operations	
Eyes			Shortness of breath		Fractures/dislocations		Serious injuries	
Blindness			Chronic cough		Knee problems		Serious illness	
Double vision			Pneumonia		Deformity		Substance abuse	
Deafness, hearing aid			Asthma		Arthritis		Psychological illness	
Perforated eardrum			Bronchitis		Back problems		Medication allergy —	
Frequent ear infections			Digestive system		Tumor or growth		please list:	
Frequent nose bleeds			Abdominal pain		Skin disorder			
Frequent sore throats			Diarrhea; chronic/recurrent		Diabetes			
Neck			Colitis, ileitis		High cholesterol		Other Allergies:	
Frequent swollen glands			Irritable bowel		Eating disorder			
Thyroid dysfunction			Gall stones		Sickle cell trait/disease			

Explanation of YES answers: \_\_\_\_\_  
 \_\_\_\_\_

**III. PHYSICAL EXAMINATION: TO BE COMPLETED BY HEALTH CARE PROVIDER.**

**To the health care provider:** Please review the student's history and complete the physician's form. This information is strictly for the use of the Health Services and will not be released without student consent.

Name: \_\_\_\_\_  
Last First Middle

Height: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_ Vision \_\_\_\_\_

Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ Resp: \_\_\_\_\_ Rt. \_\_\_\_\_ Lt. \_\_\_\_\_ \*Glasses: Rt. \_\_\_\_\_ Lt. \_\_\_\_\_

	System	Normal	Abnormal		System	Normal	Abnormal
1	Skin			11	Hernia		
2	Ears			12	Genitalia		
3	Eyes			13	Pelvic (if indicated)		
4	Nose, throat, teeth			14	Rectal		
5	Neck, thyroid			15	Lymphatic		
6	Chest, breasts			16	Extremities		
7	Lungs			17	Neurological		
8	Heart			18	Psychological		
9	Heart murmur			19	Back & spine		
10	Abdomen, liver spleen, kidneys			20	Joints, shoulders, knees & ankles		

Results of Urinalysis: \_\_\_\_\_

List any current illness(es), medications and explanations of abnormal findings: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Capable of participating in sports? Yes \_\_\_\_\_ No \_\_\_\_\_ Collision \_\_\_\_\_ Contact \_\_\_\_\_ Non-Contact \_\_\_\_\_

Signature of Health Care Provider: \_\_\_\_\_

Printed Name of Health Care Provider \_\_\_\_\_ Date of Examination \_\_\_\_\_

# IMMUNIZATION RECORD

## IV. IMMUNIZATION RECORD

To Be Completed And Signed By Your Health Care Provider. All Information Must Be In English.

### REQUIRED VACCINES:

#### A. TETANUS-DIPHTHERIA

1. Tdap, one dose required, if it has been 5 years or more since the last dose of Td .....  $\frac{\quad}{\text{Mo}} \frac{\quad}{\text{Day}} \frac{\quad}{\text{Yr}}$
2. Td within the last ten years .....  $\frac{\quad}{\text{Mo}} \frac{\quad}{\text{Day}} \frac{\quad}{\text{Yr}}$

#### B. M.M.R. (Measles, Mumps, Rubella) (two doses required)

1. Dose 1 given at 12 months after birth or later and Dose 2 given at least 4 weeks after first dose ..... 1  $\frac{\quad}{\text{Mo}} \frac{\quad}{\text{Day}} \frac{\quad}{\text{Yr}}$  2  $\frac{\quad}{\text{Mo}} \frac{\quad}{\text{Day}} \frac{\quad}{\text{Yr}}$

**OR Measles, Mumps, Rubella Titers** (clinical history is not acceptable)

#### MEASLES (Rubeola) (check all that apply)

1. Has report of positive immune titer. Specify date .....  $\frac{\quad}{\text{Mo}} \frac{\quad}{\text{Day}} \frac{\quad}{\text{Yr}}$

#### RUBELLA (German Measles) (check all that apply)

1. Has report of positive immune titer. Specify date .....  $\frac{\quad}{\text{Mo}} \frac{\quad}{\text{Day}} \frac{\quad}{\text{Yr}}$

#### MUMPS (check all that apply)

1. Has report of positive immune titer. Specify date .....  $\frac{\quad}{\text{Mo}} \frac{\quad}{\text{Day}} \frac{\quad}{\text{Yr}}$

#### C. HEPATITIS B (Three(3) doses of vaccine given as a series of three(3) age-appropriate doses (given at 0, 1-2 months after first dose and 6-12 months after first dose) or a positive Hepatitis B surface antibody meets the requirement.)

1. Dose #1  $\frac{\quad}{\text{Mo}} \frac{\quad}{\text{Day}} \frac{\quad}{\text{Yr}}$  Dose #2  $\frac{\quad}{\text{Mo}} \frac{\quad}{\text{Day}} \frac{\quad}{\text{Yr}}$  Dose #3  $\frac{\quad}{\text{Mo}} \frac{\quad}{\text{Day}} \frac{\quad}{\text{Yr}}$
2. Hepatitis B surface antibody  $\frac{\quad}{\text{Mo}} \frac{\quad}{\text{Day}} \frac{\quad}{\text{Yr}}$  Immune \_\_\_\_\_ Non-immune \_\_\_\_\_

#### D. Varicella

1. History of Disease Yes\_\_\_ No\_\_\_ OR
2. Birth in U.S. before 1980 (except students in a health program with patient contact) Yes\_\_\_ No\_\_\_ OR
3. Varicella Antibody  $\frac{\quad}{\text{Mo}} \frac{\quad}{\text{Day}} \frac{\quad}{\text{Yr}}$  Result: Immune \_\_\_\_\_ Non-immune \_\_\_\_\_ OR
4. Immunization
- a. Dose #1 given at age 12 months or later  $\frac{\quad}{\text{Mo}} \frac{\quad}{\text{Day}} \frac{\quad}{\text{Yr}}$  b. Dose #2 given at least at least 4 weeks after first dose  $\frac{\quad}{\text{Mo}} \frac{\quad}{\text{Day}} \frac{\quad}{\text{Yr}}$

#### ALL FULL-TIME STUDENTS 21 YEARS AND YOUNGER:

#### E. MENINGOCOCCAL (One dose given at age 16 or older or the enclosed waiver may be signed stating that the student has received information regarding meningococcal disease/vaccination and wishes to decline immunization.)

Vaccinated Date  $\frac{\quad}{\text{Mo}} \frac{\quad}{\text{Day}} \frac{\quad}{\text{Yr}}$  Type of Vaccine: Menomune: \_\_\_\_\_ Menactra: \_\_\_\_\_ Menveo: \_\_\_\_\_

**RECOMMENDED VACCINE:** a clinical discussion with your health care provider is recommended

Meningitis B (Trumenba) 3 doses: Dose #1  $\frac{\quad}{\text{Mo}} \frac{\quad}{\text{Day}} \frac{\quad}{\text{Yr}}$  Dose #2  $\frac{\quad}{\text{Mo}} \frac{\quad}{\text{Day}} \frac{\quad}{\text{Yr}}$  Dose #3  $\frac{\quad}{\text{Mo}} \frac{\quad}{\text{Day}} \frac{\quad}{\text{Yr}}$

Meningitis B (Bexsero) 2 doses: Dose #1  $\frac{\quad}{\text{Mo}} \frac{\quad}{\text{Day}} \frac{\quad}{\text{Yr}}$  Dose #2  $\frac{\quad}{\text{Mo}} \frac{\quad}{\text{Day}} \frac{\quad}{\text{Yr}}$

#### HEALTH CARE PROVIDER

Name \_\_\_\_\_ Address \_\_\_\_\_

Signature \_\_\_\_\_ Phone \_\_\_\_\_

**V. TUBERCULOSIS SCREENING: See enclosed TUBERCULOSIS RISK QUESTIONNAIRE**

Must be completed by all students and returned with **HEALTH & IMMUNIZATION** form.

**HEALTH INSURANCE**

Massachusetts Student Plan     Yes     No

Health Insurance Provider, if not Massachusetts State System Plan:    **PLEASE ATTACH COPY OF HEALTH INSURANCE CARD**

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**MEDICAL TREATMENT RELEASE  
FOR STUDENTS UNDER 18 YEARS**

**PARENTAL PERMISSION**

In the event that medical treatment is found to be necessary, I hereby authorize a physician or such assistants as may be selected by him to render medical treatment to my son/daughter.

If in treatment of a condition, in the exercise of professional judgment, hospitalization is deemed necessary, I hereby consent to hospital care encompassing routine diagnostic procedure, medical treatment, and surgery which may involve the administration of anesthesia.

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*Date*

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*Parent or Guardian's Signature*

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# TUBERCULOSIS RISK QUESTIONNAIRE



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**UNIVERSITY**

*Mail completed form to:*

**Worcester State University  
Student Health Services  
486 Chandler Street, Worcester, MA 01602**

Phone: 508-929-8875

Fax: 508-929-8075

Must be completed by all students and returned with the **Health & Immunization** form.

Name: \_\_\_\_\_ Birth Country: \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date Completed: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please circle your answers to the following questions:

1. Have you ever had a positive tuberculosis (TB) test (if yes, please continue onto Section B): Yes / No
2. Do you have any symptoms of active tuberculosis:
  - Cough greater than 8 weeks Yes / No
  - Cough with bloody sputum Yes / No
  - Unexplained fatigue Yes / No
  - Unexplained weight loss Yes / No
  - Night sweats Yes / No
  - Unexplained fever of 100 degrees F for over 2 weeks Yes / No
3. To the best of your knowledge, have you had close contact with anyone who was sick with TB: Yes / No
4. Were you born in one of the countries listed below: Yes / No
5. Have you ever traveled or lived for more than 1 month in any of the countries listed below: Yes / No
6. Have you ever lived, worked or volunteered in a nursing home, homeless shelter, hospital, or correctional facility: Yes / No

**High Risk:** If the answer to questions **2, 3, 4, 5, or 6** are **“Yes”**, you are **REQUIRED** to have a tuberculin skin test or blood test to check for latent tuberculosis infection. See reverse side of this page for required documentation.

**Low Risk:** If the answer to all the above were **“No”**, no further testing or further action is required.

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2012. Countries with incidence rates of?: 20 cases per 100,000 population. For future updates, refer to <http://apps.who.int/ghodata>.

# MEDICAL EVALUATION FOR LATENT TUBERCULOSIS INFECTION

(To be completed if answered yes to questions 2, 3, 4, 5, or 6)

(To be completed and signed by a healthcare provider)

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_

Please note: If patient has had a POSITIVE TUBERCULIN SKIN TEST in the past, the test should not be repeated. **Go to Section B** below.

## A. TUBERCULIN TESTING (MANTOUX/PPD OR INTEFERON GAMMA RELEASE ASSAY (IGRA))

**1. Tuberculin Skin Test**—Please note: skin test must be read by a healthcare provider 48 – 72 hours after administration.

If no Induration, mark "0".

**Date administered:** \_\_\_/\_\_\_/\_\_\_  
Mo Day Yr

**Date test read:** \_\_\_/\_\_\_/\_\_\_  
Mo Day Yr

**Result:** \_\_\_\_\_ mm of induration

**Interpretation of Tuberculin Skin Test:** (Please use table below and circle response) Negative / Positive

Risk Factor	Positive Result
Close contact with a case of TB	5mm or more
Born in a country with a high rate of TB	10 mm or more
Traveled / lived for 1 + months in a country with high TB rates	10 mm or more
No risk factors (test not recommended)	15 mm or more

**OR**

**2. Interferon Gamma Release Assay (IGRA)**

**Method used:** (Please Circle) QFT – G / Tspot      **Date obtained:** \_\_\_/\_\_\_/\_\_\_  
Mo Day Yr

**Result:** (Please check appropriate response) \_\_\_ Negative \_\_\_ Positive \_\_\_ Indeterminate/Borderline (requires repeat test)

## B. POSITIVE SKIN TEST OR POSITIVE IGRA REQUIRES A CHEST XRAY

**1. Date of POSITIVE test:** \_\_\_/\_\_\_/\_\_\_  
Mo Day YR

**Testing method:** (please circle) Skin test / IGRA

**2. Chest X- Ray:** (please circle) Normal / Abnormal      **Please attach a copy of the report**

**3. Treatment:** (please circle) Yes / No

**Medications, Dates:** \_\_\_\_\_

Healthcare Provider Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_