FAMILY MEDICAL HISTORY			
	YES	NO	RELATION
Diabetes			
Epilepsy/Seizures			
Hypertension			
Cancer *(Specify: _____)*			
Mental Health *(Specify: _____)*			
Sickle Cell Disease			
Thyroid Disease			
Sudden cardiac death before age of 50			

DISEASE/CONDITION			

TO THE EXAMINING HEALTHCARE PROVIDER: Please review the student's health history and complete this form. The information supplied will be used as a background for providing any necessary health care, and for identifying any need for accommodation to facilitate the student's academic success. This information will be handled in accordance with all applicable law.

Patient Name: _____ Date of Birth: _____

IMMUNIZATIONS/TUBERCULOSIS SCREENING:

1. Are you experiencing any possible symptoms of TB: unexplained weight loss, fevers >1 week, night sweats, persistent cough >3 weeks, cough productive of bloody sputum?

☐ YES ☐ NO

2. Do you have any risk factors for TB infection: close contact with known case of TB, use of illegal IV drugs, HIV infection, healthcare worker, resident/employee in nursing home/homeless shelter/correctional facility

☐ YES ☐ NO

3. Were you born in or traveled in the past 5 years (greater than 2 weeks) to any of the areas defined by the World Health Organization and the CDC as a region of high prevalence of TB? (see below)

☐ YES ☐ NO

Angola, Bangladesh, Brazil, China, Democratic People's Republic of Korea, Democratic Republic of the Congo, Ethiopia, India, Indonesia, Kenya, Mozambique, Myanmar, Nigeria, Pakistan, Philippines, Russian Federation, South Africa, Thailand, United Republic of Tanzania, Vietnam, Cambodia, Central African Republic, Lesotho, Liberia, Namibia, Papua New Guinea, Sierra Leone, Zambia, Zimbabwe

If you answered YES to any of the questions above, then you are required to submit a negative PPD result (Mantoux), CXR, or IGRA results (QuantiFERON or T-SPOT). (Please attach results.)

THE FOLLOWING IMMUNIZATIONS ARE REQUIRED:

- MMR (Measles, Mumps, Rubella) – 2 doses or titer
- Tetanus-Diphtheria-Pertussis (Tdap)
- Meningococcal (Meningitis, MCV4, Menveo, Menactra)

THE FOLLOWING IMMUNIZATIONS ARE RECOMMENDED:

- Varicella (Chicken pox) – 2 doses
- Hepatitis B – 3 doses
- HPV (Human Papillomavirus – Cervarix, Gardasil, Gardasil 9)
- COVID-19
- Meningococcal (MenB, Bexsero, Trumenba)
- Hepatitis A – 2 doses

PLEASE ATTACH A COMPLETE COPY OF YOUR MOST UP-TO-DATE IMMUNIZATIONS

Meningococcal Vaccine/Waiver

Pennsylvania state law provides that a student at an institute of higher education may not reside in a dormitory or campus housing unless the vaccination against meningococcal disease has been received. If a student chooses not to be vaccinated, the student (parent/guardian of minors) must sign a written waiver verifying they have chosen not to receive the meningococcal disease vaccination for religious or other reasons. Meningococcal disease is rare but a potentially fatal infection that a□ects the lining of the brain and spinal cord. More detailed information can be found on the CDC website.

I, _____, reviewed the recommendation to receive the meningococcal vaccine. I am fully aware of the risks associated with meningococcal disease and of the availability and e□ectiveness of the vaccinations against the disease. By signing this waiver, I acknowledge the risks associated with declining the vaccine.

_____ Date: _____

Signature of student (guardian if student is not 18)

Immunization Waiver

By submitting this waiver, I acknowledge that I have been informed that I may be placing myself and others at risk of serious illness should I contract a disease that could have been prevented through proper vaccination. Students who claim exemption may be kept out of classes during the course of the disease outbreak if it is determined that such students are at risk for getting that disease and transmitting it to other students. The length of time a student is excluded from classes will vary depending on the disease. I hereby attest that I am declining immunization at this time for the below identi□ed reason.

REASON (check one): ☐ Medical Reason _____ ☐ Religious/Philosophical

Signature: _____ Date: _____