2024-2025 Health Background Form

- Form for all NEW INCOMING STUDENTS
- Returning health-related program students, use the Annual Immunization Review form

University at Buffalo Student Health Services
4350 Maple Road, Amherst, NY 14226
716-829-3316 Fax: 716-829-2564

Students cannot register for classes until they have fulfilled the required immunizations

- Form must be completed and signed by a licensed health care provider or have immunization records attached.
- All immunization records must be in English.
- Submit to UB Student Health Services via the patient portal (patientportal.buffalo.edu).
- Exemption information can be reviewed at: www.buffalo.edu/studentlife/immunize

Name (please print):_____ UB Person #: _____
Last First MI

Birthdate:_____/_____/_____ Academic Program/Major: _____
Month Day Year

Emergency Contact Name & Phone #: _____

FOR STUDENTS UNDER 18 YEARS OF AGE ONLY

To avoid delays when medical problems arise, we request that the following statement be signed by a parent or legal guardian:
I hereby grant permission to UB Student Health Services to provide services, including telemedicine, to my child. This includes care and treatment by medical providers at any outside health care facility if deemed necessary by UB Student Health Services.

_____ _____
Parent/Guardian Signature Relationship Date

Section 1. Required for ALL Students	Submit dates in MM/DD/YYYY format
MMR (combined Measles, Mumps, Rubella) • Two doses of MMR vaccine (given after 01/01/1968); both administered after first birthday and at least 28 days apart **OR** • Serology (blood test): Positive IgG antibody titers confirming immunity to measles, mumps, and rubella	Dose #1_____/___/_____ Dose #2_____/___/_____ **OR** MMR Titer Date_____/____/_____ *****MUST ATTACH LAB REPORTS WITH REFERENCE RANGE*****
MENINGOCOCCAL VACCINE or WAIVER New York State requires all college students to: • Receive at least one dose of Meningococcal ACWY vaccine *within 5 years* of entering college **OR** • Receive two doses (full series) of Meningococcal B vaccine **OR** • Receive two doses (full series) of Meningococcal ABCWY **OR** • Sign a waiver specifically declining meningococcal immunization	Men ACWY Dose #1____/___/_____ **OR** Men B Dose #1____/____/_____ Men B Dose #2____/____/_____ **OR** Men ABCWY Dose #1____/_____/_____ Men ABCWY Dose #2___/_____/_____ **OR** **I acknowledge the risks associated with meningococcal infection (meningitis) and decline immunization at this time.** _____ Signature Date ***If student is under 18 years of age, parent/guardian must sign & date.***

Name (please print):_____ UB Person #: _____
Last First MI

Section 2. Required for Health-Related Students Recommended for All Other Students	**Submit dates in MM/DD/YYYY format**
New students enrolled (not *intended*) in **health-related programs includes** Athletic Training, Communicative Disorders, Dental, Dietetic Intern, Exercise Science, Medicine, Medical Technology/Biotechnology, Nuclear Medicine, Nursing, Occupational Therapy, Pharmacy, Physical Therapy.	
HEPATITIS B • Three dose series (*Heplisav-B only requires two doses)* **OR** • Serology (blood test): Positive Hepatitis B Surface Antibody, **Quantitative** Titer confirming immunity. *Serology is ***REQUIRED for all first-year medical students.*** *	Dose #1____/____/____*Circle if Heplisav-B* Dose #2____/____/____ *Circle if Heplisav-B* Dose #3____/____/____ **OR** Hepatitis B Titer Date____/____/____ *****MUST ATTACH QUANTITATIVE LAB REPORT WITH REFERENCE RANGE*****
TETANUS-DIPHTHERIA • Tetanus (Td/Tdap) booster within last 10 years • One lifetime adult **Tdap** *(contains pertussis)* is **required** • **Must complete both fields** even if the date is the same	Last Tetanus Booster Date____/____/____*Circle:* **Td** *or* **Tdap** Adult **Tdap** Vaccine Date____/____/____ *****DATES REQUIRED FOR BOTH*****
VARICELLA Must demonstrate immunity through one of the following: • Two doses of varicella vaccine; both administered after first birthday and at least 28 days apart **OR** • Medical provider/clinician documented history of varicella *(chickenpox)* disease **OR** • Serology (blood test): Positive varicella IgG antibody titer confirming immunity	Dose #1____/____/____ Dose #2____/____/____ **OR** Medical Provider/Clinician Diagnosis____/____/____ **OR** Varicella Titer Date____/____/____ *****MUST ATTACH LAB REPORT WITH REFERENCE RANGE*****
INFLUENZA • One seasonal dose given annually. List most recent dose. Include brand name on the line next to the dose date.	____/____/____ _____

Section 3. Recommended for All Students	**Submit dates in MM/DD/YYYY format**
HEPATITIS A	Dose #1_____/_____/_____ Dose #2_____/_____/_____
HUMAN PAPILLOMA VIRUS (HPV)	Dose #1_____/_____/_____ Dose #2_____/_____/_____ Dose #3_____/_____/_____
POLIO	Dose #1_____/_____/_____ Dose #2_____/_____/_____ Dose #3_____/_____/_____ Dose #4_____/_____/_____
COVID-19 VACCINE • All students are encouraged to remain up to date. List most recent dose(s). • Must include the manufacturer's name on the line next to each dose or attach an official immunization record.	____/____/____ _____ ____/____/____ _____ ____/____/____ _____

Name (please print):_____ UB Person #: _____
Last First MI

Section 4. Health Care Provider Signature REQUIRED to Certify Immunizations in Section 1, 2 and 3

Health Care Provider Signature Date

Health Care Provider Name (Print/Stamp) Health Care Provider Address & Phone Number (Print/Stamp)

Section 5. Physical Exam within past year
REQUIRED for 1st year Dental, International Dental Program(IDP), 3rd Year & ABS Nursing
Optional for all other students

Exam Findings:_____

To the best of my knowledge, this patient is free of any physical or mental impairment which is of potential risk to patients/personnel, or which might interfere with the performance of their duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, and other drugs.

If the provider cannot certify, an explanation letter with medical provider signature must accompany this form.

Health Care Provider Signature Date

Health Care Provider Name (Print/Stamp) Health Care Provider Address & Phone Number (Print/Stamp)

Name (please print):_____ UB Person #: _____
Last First MI

Section 6. Tuberculosis Screening: Parts A & B REQUIRED for ALL Students
Part C REQUIRED if YES to any question in Parts A or B

PART A: **CIRCLE**

1. Have you ever had a positive PPD, TB QuantiFERON, or T-SPOT test? **YES NO**

PART B:

1. Are you currently enrolled (**not *intended***) in a health-related program (Athletic Training, Communicative Disorders, Dental, Dietetic Intern, Exercise Science, Medicine, Med Tech/Bio Tech, Nuclear Med, Nursing, OT, Pharmacy, PT)? **YES NO**
2. Were you born in, or have you lived, worked, or visited for more than one month in any of the following: Asia, Africa, South America, Central America, or Eastern Europe? **YES NO**
   a. If yes, what country?_____ How long? _____
3. Do any of the following conditions or situations apply to you:
   a. Do you have a persistent cough (3 weeks or more), fever, night sweats, fatigue, loss of appetite, or weight loss? **YES NO**
   b. Have you ever lived with or been in close contact to a person known or suspected of being sick with TB? **YES NO**
   c. Have you ever lived, worked, or volunteered in any homeless shelter, prison/jail, hospital, or drug rehabilitation unit, nursing home or residential healthcare facility? **YES NO**

Student Signature_____ Date _____

**SKIP if NO to all the above questions*

PART C: REQUIRED IF YES TO ANY OF THE ABOVE QUESTIONS – TO BE COMPLETED BY YOUR MEDICAL PROVIDER

ATTENTION MEDICAL PROVIDER:

- If the student answered YES to any of the above questions, a TB test (PPD, T-SPOT, or TB QuantiFERON) is REQUIRED.
  - TB test must be completed within one calendar year *(unless history of positive TB test – see below)*.
  - **MUST ATTACH LAB REPORT IF T-SPOT OR TB QUANTIFERON IS COMPLETED**
- If PPD result is 10mm or more, or T-SPOT or TB QuantiFERON is positive, a chest x-ray is REQUIRED.
- If the student has a history of a positive TB test, document date and result of the test and chest x-ray, as well as treatment information.
  - It is *not necessary* for these students to repeat TB testing or the chest x-ray.
- History of BCG vaccination does *not* exclude the student from this requirement.

PPD Date Placed:	PPD Date Read:	Induration/ Measurement (in mm):
OR		
QuantiFERON-TB Gold *or* T-Spot Collected Date:	QFT-G or T-Spot Result *(circle)*: ****MUST ATTACH LAB REPORT****	Positive Negative Equivocal

****Chest X-ray REQUIRED IF: PPD ≥ 10mm *or* Positive QuantiFERON-TB Gold/T-SPOT****

Chest X-Ray Date:	Chest X-Ray Result:

1. Does the student have any of the following symptoms: cough with sputum production > 3 weeks, bloody sputum, unintended weight loss > 10 pounds, drenching night sweats, unexplained fever, fatigue > 3 weeks? **YES NO**
2. If negative chest x-ray and positive TB test, did the student complete a course of INH or other TB treatment? **YES NO**
   a. If yes, name & dose of medication_____
   b. Date range of treatment_____ Number of months of treatment_____

_____
Health Care Provider Signature Date

_____
Health Care Provider Name (Print/Stamp) Health Care Provider Address & Phone Number (Print/Stamp)