

Dear Student:

Congratulations on your acceptance to Radford University and welcome to our Highlander Family. We at Radford University Student Health are here to assist and support your health and wellness needs during your time at Radford University. To help us care for you, we need some general health information including, documentation of immunizations required by the Code of Virginia, Section 23.1-800.

Immunization records may be obtained by contacting your family doctor, your parents, the high school from where you graduated, previous university attended, military immunization records, or your local health department.

Before submitting your form, please note the following requirements:

- If under age 18 upon arrival on campus, parent or legal guardian signature is required on the Health Record Form and the Consent for Treatment of Minors.
- Completed Health Record Form, including all required and recommended immunization administration dates, submitted via [https:// Radford.medicatconnect.com](https://Radford.medicatconnect.com).
- Healthcare Provider signature (must be MD, DO, NP or PA) on Certificate of Immunizations.
- Waivers signed, if applicable, for Hepatitis B and/or Meningococcal vaccines.
- Medical Exemption, if applicable, signed by healthcare provider (MD, DO, NP or PA) or Health Department Official.
- Healthcare Provider (MD, DO, NP or PA) signature on Tuberculosis Screening.

The Health Record Form can be submitted online at the secure website <https://Radford.medicatconnect.com>. Chose Radford University as your college and log in using your Radford University credentials (username and password) to access the online system.

Please note that incomplete immunizations or missing documentation will result in being blocked from pre-registration for the next semester.

If you have any questions or concerns regarding the completion of your record, please contact Student Health Services at 540-831-5111.

Sincerely,  
Abby Mundy  
Director of Student Health Services

Thomas Knisely, D.O.  
Medical Director, Student Health Services

# Radford University Health Record Form

To meet the requirements of the Commonwealth of Virginia Law (Code of Virginia, Section 23.1-800) all required immunizations must be current and appropriately documented on the Radford University Health Record, Certificate of Immunization, and Tuberculosis Screening form completed and signed by a physician or licensed health care provider. **The completed forms must be submitted online to the Student Health Center prior to enrollment (by June 1 for fall semester and December 1 for spring semester). If admitted after deadline, all documentation must be submitted within 30 days of enrollment.**

Using your RU credentials, log in to <https://Radford.medicatconnect.com> or thru MyRU Portal and manually enter vaccine administration dates, test results, and upload all three pages of this form. **Keep in mind that incomplete immunizations or documentation will prevent your pre-registration for second semester.**

## Personal Information

Name \_\_\_\_\_ Student ID# \_\_\_\_\_  
Last First Middle (University Student ID # is required to process this form.)

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_  
Mo Day Year

College Address \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_  
No. & Street City State Zip

Permanent Home Address \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_

Parent/Guardian Email Address \_\_\_\_\_

**In Case of Emergency, Notify** \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
*Required* Name Telephone Relationship

Family Physician \_\_\_\_\_  
Name Address

Date of Entrance:  Fall  Spring 20\_\_\_\_ Previously Enrolled:  Yes  No  
Date of previous attendance: \_\_\_\_\_  
Previous Name, if different than when last enrolled: \_\_\_\_\_

## Medical History (Confidential)

1. Name any chronic illness or major medical condition for which you are being treated. Please also list any hospitalizations / surgeries.  
\_\_\_\_\_  
\_\_\_\_\_
2. List medications you are currently taking \_\_\_\_\_  
\_\_\_\_\_
3. List any medicine, food, or environmental substance to which you are ALLERGIC and describe allergic reaction.  
\_\_\_\_\_

### Consent for Treatment of Minors (Students 17 years and younger)

The Radford University Student Health Center has my permission to treat my minor child in the event of a medical emergency. Radford University Student Health Center also has my permission to treat my child for routine medical care, including check-ups, immunizations, and/or treatment for minor injuries and illnesses.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

# Radford University Certificate of Immunization

Name: \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Student ID# \_\_\_\_\_  
University Student ID # is required to process this form.

**Do NOT send copies of immunization records. Immunizations must be entered on this form and signed by a health care provider.**

REQUIRED IMMUNIZATIONS	VACCINE DOSES ADMINISTERED			
<b>1. HEPATITIS B</b> (For combined Hep. A + B, do not use this line. Instead, check here: <input type="checkbox"/> and complete the appropriate line in "Recommended but Not Required") Titer <input type="checkbox"/> Pos <input type="checkbox"/> Neg ____/____/____	1) ____/____/____ M D Y	2) ____/____/____ M D Y	3) ____/____/____ M D Y	Date Series completed ____/____/____ M D Y
<b>2. MENINGOCOCCAL VACCINE (ACYW – 135)</b> Must have at least one vaccine after the age of 16.	1) ____/____/____ M D Y	2) ____/____/____ M D Y	Menactra Menomune Menveo	
<b>3. MEASLES, MUMPS, RUBELLA (MMR)</b> Students born before 1957 are not required to have a second MMR vaccination.	1) ____/____/____ M D Y	2) ____/____/____ M D Y	OR titer(s) indicating positive immunity. <b>Must attach lab results.</b>	
<b>4. TETANUS DIPHTHERIA acellular PERTUSSIS (Tdap)</b> Within last 10 years.	____/____/____ M D Y			
<b>5. POLIOMYELITIS (OPV or IPV)</b>	Have you completed the series? <input type="checkbox"/> Yes <input type="checkbox"/> No Date completed: ____/____/____ M D Y			
RECOMMEND IMMUNIZATIONS	VACCINE DOSES ADMINISTERED			
<b>1. SEROGROUP B MENINGOCOCCAL VACCINE</b> <input type="checkbox"/> 2 Dose On or after 2016 <input type="checkbox"/> 3 Dose	1) ____/____/____ M D Y	2) ____/____/____ M D Y	3) ____/____/____ M D Y	Bexsero Trumenba
<b>2. HPV, Quadrivalent or Bivalent (age 26 or under)</b>	1) ____/____/____ M D Y	2) ____/____/____ M D Y	3) ____/____/____ M D Y	
<b>3. HEPATITIS A</b>	1) ____/____/____ M D Y	2) ____/____/____ M D Y		
<b>4. COMBINED HEPATITIS A + B VACCINE</b> Hepatitis B is required. See above.	1) ____/____/____ M D Y	2) ____/____/____ M D Y		
<b>5. PNEUMOCOCCAL VACCINE (High-risk individuals)</b>	1) ____/____/____ M D Y			
<b>6. VARICELLA (Strongly recommended for college students)</b> (Two doses for individuals with no history of disease)	1) ____/____/____ M D Y	2) ____/____/____ M D Y	<input type="checkbox"/> Had disease: Date: ____/____/____ M D Y	OR titer indicating immunity. <b>Must attach lab results.</b>
<b>7. INFLUENZA (flu) VACCINE</b>	1) ____/____/____ M D Y			

**Hepatitis B Vaccine Waiver**  
 Review vaccine information before signing:  
[http://www.immunize.org/vis/hepatitis\\_b.pdf](http://www.immunize.org/vis/hepatitis_b.pdf)  
 I have read and reviewed information on the risk associated with Hepatitis B disease, availability and effectiveness of any vaccine against Hepatitis B and I choose not to be vaccinated against Hepatitis B disease.

\_\_\_\_\_  
 Signature of Student or Parent/Legal Guardian      Date

**Meningococcal Vaccine Waiver**  
 Review vaccine information before signing:  
[http://www.immunize.org/vis/meningococcal\\_mcv\\_mpsv.pdf](http://www.immunize.org/vis/meningococcal_mcv_mpsv.pdf)  
 I have read and reviewed the information on the risk associated with meningococcal disease, availability and effectiveness of any vaccine against meningococcal disease and I choose not to be vaccinated against meningococcal disease.

\_\_\_\_\_  
 Signature of Student or Parent/Legal Guardian      Date

**Religious Exemption**  
 Any student who objects on the grounds that administration of immunizing agents conflicts with his religious tenets or practices shall be exempt from the immunization requirements unless an emergency of epidemic disease has been declared by the Board of Health. An affidavit of religious exemption must be submitted on a Certificate of Religious Exemption (**Form CRE-1**) found at  
[http://www.doe.virginia.gov/support/health\\_medical/certificate\\_religious\\_exemption.pdf](http://www.doe.virginia.gov/support/health_medical/certificate_religious_exemption.pdf).

**HEALTH CARE PROVIDER SIGNATURE (MD, DO, NP, PA)**

Printed Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

†**Medical exemption**      \*Does not apply to tuberculosis (TB) screening/testing  
Tdap      Td      Hepatitis B      Measles      Rubella      Mumps      Meningococcal      Poliomyelitis

As specified in §23.1-800 of the Code of Virginia, I certify that administration of the vaccine(s) designated above would be detrimental to this student's health.  
 The vaccine(s) is (are) specifically contraindicated because \_\_\_\_\_  
 This contraindication is permanent (or) temporary and expected to preclude immunization until \_\_\_\_\_

\_\_\_\_\_  
 Signature of Physician, NP, or PA or Health Department Official      Date

# Radford University Tuberculosis Screening

Fill out the first section and take to your health care provider with your certificate of immunization

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Student ID Number: \_\_\_\_\_

**TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER. TB screening must be completed within six months.**

Please answer **ALL** the following questions.

**1. Does the student have signs or symptoms of active TB disease?**  YES  NO

**IF NO**, proceed to question 2.

**IF YES**, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, QFT-TB test, chest x-ray and sputum evaluation as indicated. Documentation required that all tests are negative or that treatment is effective and student free of communicable disease.

**2. Is the student a member of a high-risk group?**  YES  NO

Categories of high-risk students include those with HIV infection; who inject drugs; who have resided in, volunteered in or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal bypass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone > 15mg/d for > 1 month) or other immunosuppressive disorders.

**IF NO**, continue to question 3.

**IF YES**, Perform TST or obtain QFT (preferred). **IF positive TST**, obtain QFT.

**TST:** Date Given: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Read: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_ mm (transverse induration)

**OR**

**QFT-TB** Date Obtained: \_\_\_\_/\_\_\_\_/\_\_\_\_ **Result:**  Positive  Negative

If positive QFT, see INTERPRETATION below:

**INTERPRETATION** (based on mm of induration as well as risk factors):  Positive  Negative

If positive, please obtain QFT: Date Obtained: \_\_\_\_/\_\_\_\_/\_\_\_\_ **Result:**  Positive  Negative

If positive QFT, obtain CXR: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ **Result:**  Normal  Abnormal - return to Question 1 - yes

If normal CXR, INH initiated Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_

**3. Was the student BORN in, LIVED or TRAVELED to countries OTHER THAN those on the following list?**  YES  NO

Albania, American Samoa, Andorra, Antigua and Barbuda, Aruba, Australia, Austria, Bahamas, Barbados, Belgium, Bermuda, British Virgin Islands, Canada, Cayman Islands, Chile, Cook Islands, Costa Rica, Cuba, Curacao, Cyprus, Czech Republic, Denmark, Dominica, Egypt, Finland, France, Germany, Greece, Grenada, Iceland, Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Luxembourg, Malta, Monaco, Montenegro, Montserrat, Netherlands, New Zealand, Norway, Oman, Puerto Rico, Saint Kitts and Nevis, St. Lucia, Samoa, San Marino, Saudi Arabia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tokelau, Tonga, Trinidad & Tobago, United Arab Emirates, United Kingdom, United States Virgin Islands, West Bank and Gaza Strip, United States of America

**IF NO:** No TST Required. Please sign below.\*

**IF YES:** Obtain QFT: Date obtained: \_\_\_\_/\_\_\_\_/\_\_\_\_ **Result:**  Positive  Negative **If negative, sign form below.**

If positive QFT: Obtain CXR: Date obtained: \_\_\_\_/\_\_\_\_/\_\_\_\_ **Result:**  Normal  Abnormal

**If abnormal CXR, return to Question 1 – yes.**

If normal CXR: INH initiated: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_

**\*HEALTH CARE PROVIDER SIGNATURE (MD, DO, NP, PA) Signature required as validation of TB assessment.**

*NOTE: Current CDC guidelines recommend treatment of positive results. To verify positive TST results, a serology IGRA (QFT) should be obtained. A CXR only confirms active disease and does not rule out latent disease.*

Printed Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Required vaccinations/screening for all students:**

1. Hepatitis B: Students must have documentation of a completed vaccination series. The Twinrix immunization series is an acceptable alternative, as is a titer proving immunity (please provide a copy of the report with the date and result of positive titer). Students may choose to sign a waiver for this immunization.
2. Meningococcal Vaccine: For students younger than 22 years of age, one dose of vaccine required after age 16 or signed waiver. Meningitis B vaccines (Trumenba and Bexsero) do not meet this requirement.
3. Measles, Mumps, Rubella (MMR): Two doses of MMR or individual vaccines of each required, at least 4 weeks apart, given on or after the first birthday. Not required if born before 1957. Titers proving immunity are acceptable; please provide a copy of the report with the date(s) and result(s) of positive titer(s).
4. Tetanus Diphtheria-Pertussis: Primary series (DTap, DTP, DT or Td) plus booster within the last 10 years of fall entry or spring entry. Tdap is the preferred one time booster. Tdap may be given regardless of interval since last Td.
5. Polio: Completed primary series is required. Please provide all dates as well as any boosters received since that date. A titer proving immunity is acceptable; please provide the date of a positive titer; please provide a copy of the report with the date and result of positive titer.

Tuberculosis Screening/Testing: “Tuberculosis Screening” is **required for all students**. “Tuberculosis Testing” is also required for students who answer “yes” to any question on page 4. All screening/testing must be completed on or after 2/1 (fall entry) or 7/1 (spring entry).

**Recommended vaccinations for all students:**

1. Neisseria meningitides (Meningitis) Serogroup B vaccine: Recommended for high risk students with a history of persistent complement component deficiencies or patients with anatomic or functional asplenia. May also be given to anyone 16-23 years old to provide short-term protection. This can be either a two or three shot series depending upon the vaccine (Trumenba or Bexsero). The same vaccine must be used for all doses.
2. HPV Vaccine: The three-shot series is recommended for all females ages 11-26 and males ages 11-21. It is also approved for males up to age 26 in certain situations, see CDC guidelines.
3. Hepatitis A: Either alone or in combination with Hepatitis B as Twinrix (combination of Hepatitis A & B). Entering this information in the Hepatitis B section and indicating Twinrix is sufficient documentation.
4. Pneumococcal Vaccine: Recommended for high-risk individuals. CDC recommends PCV13 for use in infants and young children and adults 65 years or older. Older children and adults younger than 65 years old who are at increased risk for getting pneumococcal disease may also need a dose of PCV13.
5. Varicella (chicken pox): Two doses of vaccine, at least 4 weeks apart, is **strongly recommended** for all college students without other evidence of immunity (e.g. born in the U.S. before 1980, a history of disease, or a positive antibody).
6. Influenza (Flu) vaccine: All students are strongly encouraged to receive seasonal influenza (flu) vaccine when it is available beginning in early fall.

## Waiver Information for Hepatitis B and Meningococcal Disease

*Please read the following information on Hepatitis B and Meningococcal Disease before signing the waiver on the Certificate of Immunization.*

Hepatitis B	Meningococcal Disease
<p>Hepatitis B is a potentially fatal disease that attacks the liver. The virus can cause short-term (acute) illness that leads to loss of appetite, tiredness, diarrhea and vomiting, jaundice (yellow skin or eyes) and pain in muscles, joints and stomach. Many people have no symptoms with the illness. It can also cause long-term (chronic) illness that leads to liver damage, liver cancer and death.</p> <p>According to the Centers for Disease Control, about 800,000 – 1.4 million people in the U.S. have chronic Hepatitis B infection. Each year approximately 40,000 people, mostly young adults, become infected with Hepatitis B virus. Young adults are more likely to contract Hepatitis B infection due to greater likelihood of high-risk behaviors such as multiple sexual partners.</p> <p>Approximately 3,000 people die from chronic Hepatitis B infection annually. It is spread through contact with blood and body fluids of an infected person, such as having unprotected sex with an infected person or sharing needles when injecting illegal drugs. Unvaccinated health-science students are at risk of contracting Hepatitis B through an accidental occupational needle stick exposure.</p> <p>There are several ways to prevent Hepatitis B infections including avoiding risky behavior, screening pregnant women and vaccination. Vaccine is the best prevention. The vaccine series typically consists of three injections given over a six month period, which are available through your private health care provider, health department or Student Health Services. Remember: Completion of the vaccine series is needed for protection against Hepatitis B disease.</p>	<p>Meningococcal disease is the leading cause of bacterial meningitis in children 2-18 years old in the U.S. Meningitis is an infection of the brain and spinal cord coverings. Meningococcal disease can also cause blood infections. According to the Centers for Disease Control, about 2,600 people get meningococcal disease each year in the U.S. Of these cases, 10-15% die and of those who live, another 10% may require limb amputation, develop kidney failure or brain damage, become deaf, suffer seizures or strokes. College freshmen, particularly those who live in dormitories, have a slightly increased risk of getting meningococcal disease as illustrated by a case rate of 5.4/100,000 18-23 year olds as opposed to a case rate of 1.4/100,000 18-23 year olds in the general population. Meningococcal vaccine is effective in preventing four types of meningococcal disease including two of the three most commonly occurring types in the U.S. The vaccine is 85-100% effective in preventing serotype A and C in older children and adults. It does not however protect against serotype B which causes one third of cases in patients 15-24 years. Therefore, in the event of an outbreak, even previously immunized individuals should contact their health care providers.</p> <p>ACIP recommends routine vaccination of persons with meningococcal conjugate at age 11 or 12 years with a booster dose at age 16. Persons who receive their first meningococcal conjugate vaccine at or after 16 years do not need a booster dose. Routine vaccination of healthy persons 21 years or older who are not at increased risk of exposure to N. Meningitides is not recommended. The vaccine is available through your private healthcare provider, most local health departments and Student Health Services.</p>