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.
- 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                 Thomas Knisely, D.O.
Director of Student Health Services    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](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

No. & Street City State Zip Cell Phone ( )

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**

**REQUIRED IMMUNIZATIONS**

<table>
<thead>
<tr>
<th>VACCINE DOSES ADMINISTERED</th>
<th>Date Series completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HEPATITIS B</td>
<td>1/ / / M D Y</td>
</tr>
<tr>
<td>(For combined Hep. A + B, do not use this line. Instead, check here: ☐ and complete the appropriate line in “Recommended but Not Required”) Titer ☐Pos ☐Neg / / / / / / / / / /</td>
<td></td>
</tr>
<tr>
<td>2. Meningococcal Vaccine (ACYW – 135) Must have at least one vaccine after the age of 16.</td>
<td>1/ / / M D Y ☐ Menactra ☐ Meningococcal Vaccine</td>
</tr>
<tr>
<td>3. MEASLES, MUMPS, RUBELLA (MMR) Students born before 1957 are not required to have a second MMR vaccination.</td>
<td>1/ / / M D Y ☐ OR titer(s) indicating positive immunity. Must attach lab results.</td>
</tr>
<tr>
<td>4. TETANUS DIPHTHERIA acellular PERTUSSIS (Tdap) Within last 10 years.</td>
<td>/ / / M D Y</td>
</tr>
<tr>
<td>5. POLIOMYELITIS (OPV or IPV) Have you completed the series? ☐Yes ☐No Date completed: / / / M D Y</td>
<td></td>
</tr>
</tbody>
</table>

**RECOMMEND IMMUNIZATIONS**

<table>
<thead>
<tr>
<th>VACCINE DOSES ADMINISTERED</th>
<th>Date Series</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sero Group B Meningococcal Vaccine On or after 2016 ☐ 2 Dose ☐ 3 Dose</td>
<td>1/ / / M D Y 2/ / / M D Y 3/ / / M D Y ☐ Bexsero ☐ Trumenba</td>
</tr>
<tr>
<td>2. HPV, Quadrivalent or Bivalent (age 26 or under)</td>
<td>1/ / / M D Y 2/ / / M D Y 3/ / / M D Y</td>
</tr>
<tr>
<td>3. HEPATITIS A</td>
<td>1/ / / M D Y 2/ / / M D Y</td>
</tr>
<tr>
<td>4. COMBINED HEPATITIS A + B VACCINE Hepatitis B is required. See above.</td>
<td>1/ / / M D Y 2/ / / M D Y</td>
</tr>
<tr>
<td>5. Pneumococcal Vaccine (High-risk individuals)</td>
<td>1/ / / M D Y</td>
</tr>
<tr>
<td>6. Varicella (Strongly recommended for college students) (Two doses for individuals with no history of disease)</td>
<td>1/ / / M D Y 2/ / / M D Y ☐ Had disease: Date: / / / M D Y OR titer indicating immunity. Must attach lab results.</td>
</tr>
<tr>
<td>7. influenza (flu) Vaccine</td>
<td>1/ / / M D Y</td>
</tr>
</tbody>
</table>

**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 __________________

AD 3 (Rev. 2/2018 BOV approved 12/2017)
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 TST:  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_______________________

AD 3 (Rev. 2/2018 BOV approved 12/2017)
**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 lastTd.

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.

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