The pre-entrance health record/immunization form is due **August 1st** for full-time students enrolling in the Fall semester and **January 2nd** for students enrolling in the Spring. Do not submit form until **ALL information is complete**. We require you to complete all vaccines (the Hepatitis B series should be started and may be completed during the school year). However, your immunization status will not be complete until all 3 doses have been received.

Virginia state law and Old Dominion University require all full-time students taking at least one credit on the Norfolk campus who enroll for the first time, to provide documentation of immunizations by a licensed health professional or health facility. Information regarding dates of immunizations is usually available from your health care provider or last high school attended. **Students will not be allowed to register for second semester until requirements have been met.**

All full-time students admitted to Old Dominion University must provide health information. Some questions are of a personal nature. It is necessary, however, to complete all questions in order to properly evaluate each student’s risk factors for tuberculosis (TB) exposure or infection.

To ensure that we can review this form in time for registration, please have all required immunizations completed and recorded. The information on this pre-entrance health record is needed to both protect the health of the university community and to assist Student Health Services staff to provide for medical needs while a student is attending Old Dominion University. Students should bring a copy of their health insurance card with them to campus. We recommend any necessary dental and eye examinations be done before coming to the University. Student Health Services is unable to provide these services.

Student Health Services gives allergy injections at regularly scheduled times. A physician’s detailed orders are required. If starting a series of allergy shots, we require that the ordering physician give the first injection.

Please refer to our FAQ’s on our website for more information.

Submit original and keep a copy of this completed form for your records.

**This form must be returned to Student Health Services by fax or mail. Please do not do both.**
PART A. To be completed by student

Last Name | First Name | Middle Initial | University Identification No.
-----------|------------|----------------|-------------------------

Permanent Home Address Street | City | State | Zip | Phone

Year/Semester Entering ODU | Birthdate (mm/dd/yyyy) | Sex: M F | Ethnicity | Height: (ft. in.) | Weight: (lbs.)

Person to notify in case of emergency | Relationship | Phone (H) | Phone (Cell)

School Status: ☐ Full-time undergraduate ☐ Part-time undergraduate ☐ Full-time graduate ☐ Part-time graduate

Have you previously submitted an immunization report? ☐ YES ☐ NO E-mail:

Insurance: All students are recommended to have health insurance. International students must have health insurance. Do you have health insurance? ☐ YES ☐ NO

Insurance Company Policy Holder I.D./Group Number

Family History – Check if condition exists in your family (immediate family, grandparents, aunts, uncles, cousins)

Cancer ☐ | High Blood Pressure ☐ | Psychiatric Disorders ☐ | Family History of sudden death before age 50 ☐

Diabetes ☐ | Kidney Disease/stones ☐ | Suicide ☐ | Yes ☐ No ☐

Heart Disease ☐ | Asthma/Lung Disease ☐ | Tuberculosis ☐ | Yes ☐ No ☐

Personal Medical History

Allergies to Food, Drugs, Animals, Dust, Pollen, etc. List

Medicines routinely taken: (name, dosage, and frequency):

Do you have a history of any of the following medical conditions? Provide details of positive answers below.

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Yes</th>
<th>No</th>
<th>Medical Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies, Hay Fever</td>
<td></td>
<td></td>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
<td>Kidney infection/stone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
<td>Mononucleosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td>Seizure disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding Disorder</td>
<td></td>
<td></td>
<td>Stomach/Intestinal disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer or malignancy</td>
<td></td>
<td></td>
<td>Substance/alcohol abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td>Thyroid disorder</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Any other illness:

Hospitalizations:

Surgery:

Please describe any prior or current treatment by a mental health provider such as a psychiatrist, psychologist or counselor.

PERMISSION FOR TREATMENT

I understand that the information that I have given in the Pre-entrance Health Record is confidential and for the use of attending medical staff. I give permission to Old Dominion University to provide diagnostic, therapeutic, voluntary immunization, operative procedures and transportation as deemed necessary by the medical staff on my behalf. I understand that my health information will be used as necessary to coordinate and manage my health care, support the operations of Student Health Services and to comply with state/federal laws.

DEEMED CONSENT FOR HIV TESTING (VIRGINIA STATE LAW) 32.1-45.1

Testing required if direct exposure to body fluids outlined in CDC guidelines.

AUTHORIZATION OF PAYMENT

I hereby authorize Old Dominion University to bill me for services provided. I will be responsible for any legal and/or collection fees resulting from non-payment. Permission is given to Old Dominion University, Student Health Services to release information upon request regarding claim for the noted charges, to my insurance company, to facilitate payment of insurance claims.

I have been informed of and understand the above statements regarding permission for treatment, deemed consent and authorization of payment. Student’s Signature (No treatment will be given if not signed) Date / /

FOR STUDENTS UNDER 18 YEARS: CONSENT FOR TREATMENT OF MINORS

This consent form must be signed by the natural parent or legal guardian of minors (under 18 years) so that appropriate diagnosis and treatment may be promptly carried out, and so that no unnecessary delays will occur with health service procedures. Under certain circumstances the student will be transported to local hospitals for diagnosis and treatment. I have been informed of and understand the above statements regarding permission for treatment, deemed consent and authorization of payment.

I give permission for such diagnostic, therapeutic, voluntary immunization, operative procedures and transportation as deemed necessary for my son/daughter who is under the age of eighteen (18) years. No treatment will be given if not signed.

Parent/Guardian Name Parent/Guardian Signature Date / /
Part B. Tuberculosis Risk Assessment Must Be Completed By Student

Name: ___________________________ UIN: ___________________________

The United States Public Health Service and the Centers for Disease Control and Prevention recommend that tuberculosis screening be performed in all individuals who may be at increased risk of tuberculosis.

Place a check in the yes or no boxes in front of any section. A TB skin test or IGRA blood test is required if yes is checked in any section.

☑ Yes ☐ No  Section 1: Check if you have any of the following symptoms:
• Persistent cough of unknown etiology for more than 3 weeks
• Coughing bloody sputum
• Unexplained fever for more than 1 week
• Unexplained weight loss
☐ Yes ☐ No  Section 2: Check if any of these situations apply to you:
• Close contact with a known or suspected case of active tuberculosis
• Use of illegal injected drugs
• At risk of being infected with HIV (Human Immunodeficiency Virus)
• Volunteer, resident, or employee in a healthcare facility or congregate living setting (homeless shelter, nursing home, correctional facility)

☑ Yes ☐ No  Section 3: Check if you have any of the following health condition risk for tuberculosis:
• Gastrectomy, jejunoileal bypass, or chronic malabsorptive conditions
• Prolonged corticosteroid therapy or other immunosuppressive therapy; chemotherapy
• On any TNF antagonist medication (such as Humira, Embrel, or Remicade)
• Diabetes
• Chronic renal failure or on dialysis
• Solid organ transplant (kidney, heart)
• HIV infection
• Cancers of the head or neck
• Leukemia, lymphoma
• Silicosis/Pulmonary Fibrosis
• Underweight or malnourished
• Previous positive TB skin test or blood test

☑ Yes ☐ No  Section 4: Check if you have lived in or traveled to any country in the following areas of the world for a duration of 3 months or more within the past 5 years:
• Africa
• Asia
• Central America, including Mexico
• India and other Indian Subcontinent nations
• Eastern Europe
• Middle East
• South America
• Caribbean {except Jamaica, Saint Kitts and Nevis, Saint Lucia, Virgin Islands (USA)}

Country of birth: ___________________________
U.S. arrival date: ___________________________
Lived or traveled to what country: ___________________________
Length of time: ___________________________
Date of Travel: ___________________________

To be completed by health care provider if TB risk factors listed in 1 or more sections above {TB skin test or IGRA blood test is required}. Prior BCG vaccine does not exempt student from TB testing.

1. Tuberculin Skin Test (must be placed on or after June 15 for fall semester or November 1 for spring semester)
   Date applied: ____________ Date read: ____________ Result (millimeters of induration): ____________
   Interpretation (based in mm of induration as well as risk factors): ☐ Positive ☐ Negative

2. Interferon Gamma Release Assay (IGRA) drawn on or after June 15 for fall semester or November 1 for spring semester. Attach report
   Date obtained: ____________ Specify method: ☐ QTF-G ☐ QTF-GIT ☐ T-Spot
   Result: Negative ________ Positive ________ Indeterminate ________ Borderline ________

3. Chest X-Ray (required on or after June 15 for fall semester or November 1 for spring semester if Tuberculosis Skin test or IGRA listed above is positive)
   Date of chest x-ray: ____________ Result: ☐ Normal ☐ Abnormal
   INH Initiated: ☐ Yes ☐ No If yes, Date Initiated: ____________

4. History of past positive PPD or IGRA (please circle):
   Date of positive PPD/IGRA: ____________ Date INH completed: ____________
   INH not initiated (chest x-ray required or after June 15 for fall semester or November 1 for spring semester) Date of x-ray ____________ Result: ☐ Normal ☐ Abnormal

Healthcare Provider signature: __________________________________________ Date: __________________________
Healthcare Provider address and clinic stamp: ____________________________________________________________________________

SUBMIT THIS FORM WITH YOUR IMMUNIZATION DOCUMENTATION
Part C. To be completed and signed by a health care provider (except Meningococcal and Hepatitis B waivers)

Student’s Name_______________________________________________ UIN __________________________________

Required Immunizations

1. Meningococcal Vaccine (Given on or after the 16th birthday) _________________ Vaccine used: □ Menactra □ Menomune □ Menveo
   or signed Waiver (see below). Vaccine information on SHS website.

   WAIVER: I have been fully informed of the risks and health hazards of meningococcal infection as well as the benefits of the Meningococcal vaccine. I choose not to be immunized against meningococcal infection.

   Student signature (parent/legal representative if under age 18):______________________________________ _________________________

2. M.M.R. (Measles, Mumps, Rubella) Age exempt for measles/mumps/rubella? Yes____ No____
   (after 1st birthday and after May 1971) (Born before 1957)
   Dose 1: _______________________
   Month Day Year
   Dose 2: _______________________
   Month Day Year

   OR INDIVIDUAL VACCINES

   Measles (2 doses not prior to 1968)
   Dose 1: ________________
   Month Day Year
   Dose 2: ________________
   Month Day Year

   Mumps (2 doses not prior to June 1969)
   Dose 1: ________________
   Month Day Year
   Dose 2: ________________
   Month Day Year

   Rubella (1 dose not prior to June 1969)
   Dose 1: ________________
   Month Day Year
   Dose 2: ________________
   Month Day Year

   or Attach laboratory proof of immunity to all 3 diseases.

3. Tetanus-Diphtheria OR Tdap
   (Within last 10 years)
   _______________________
   Month Day Year

4. Polio (Series Completed)
   (Within last 10 years)
   _______________________
   Month Day Year

5. Hepatitis B: Completed series? Yes___ No___ Dates: 1)____/____/____ 2)____/____/____ 3)____/____/____
   or Merck 2 dose adolescent series: Dates: 1)____/____/____ 2)____/____/____
   or signed Hepatitis B Waiver (see below) Vaccine information available on SHS website.

   WAIVER: I have been fully informed of the risks and health hazards of hepatitis B infection as well as the benefits of the hepatitis B vaccine. I choose not to be immunized against hepatitis B infection.

   Student signature (parent/legal representative if under age 18):__________________________________________________________ _______

HEALTH CARE PROVIDER

I have reviewed the immunization records of this patient and certify that the entries above are correct.

______________________                  _____________________________
Signature of Health Professional                                                    Date                                                   Telephone

Printed Name of Health Professional                                            Office Address and Clinic Stamp

Medical Exemption from Immunization Requirement

The physical condition of the above-named individual is such that immunization would endanger life or health.

Condition:___________________________________________________________________________________________

Exemption: Permanent____________      Temporary (Exemption Expires on) _____________________________________

Signature and Title of Medical Provider_________________________________    Date_____________________________

Religious Exemption from Immunization Requirement (TB screening is still required)

A notarized letter from spiritual leader is required or CRE – 1 form from Virginia Department of Health. I adhere to a religious belief whose teachings are opposed to immunization. By Refusing to be immunized, I realize that I will be excluded from classes and required to leave the campus during an outbreak of communicable disease, as determined by the campus health officials. I release Old Dominion University and its employees from responsibility for any impairment to my health resulting from this exemption.

Signature ______________________________________________________     Date _____________________________