



**West Chester University  
Student Health Form and Immunization Record**

Mail or fax to: West Chester University  
Student Health and Wellness Center  
West Chester, PA 19383  
Phone 610-436-2509  
Fax 610-436-3148

**PART I: To be completed by student.** All information is strictly confidential. No information will be released without the student's consent.

\_\_\_\_\_  
Last Name First MI

\_\_\_\_\_  
Student ID # Gender Date of Birth

\_\_\_\_\_  
Permanent Address

\_\_\_\_\_  
Phone # Cell #

**EMERGENCY CONTACT:**

Name and Relationship to Student: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**HEALTH INSURANCE INFORMATION:**

Plan: \_\_\_\_\_ Policy ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Phone number to call for authorizations: \_\_\_\_\_

**HEALTH INFORMATION:**

**ALLERGIES:** Please list any medication allergies and other allergies, including foods, insects, latex.

Name of drug or other allergy	Type of reaction	Name of drug or other allergy	Type of Reaction



**2. If living on campus: MENINGITIS (Meningococcal Quadrivalent)**

Pennsylvania state law requires all students, who live in university housing, to provide either proof of vaccination for meningitis or a signed waiver requesting exemption after having received information on the risks associated with meningococcal disease and the availability and effectiveness of the vaccine. The CDC now recommends a booster dose for those 16 years of age who received their initial dose at age 11-12. If the initial dose was given at 13-15 years, the booster dose should be given at 16-18 years of age. If the initial dose was given at age 16 years or older, no booster is needed, except where there is continuing risk. Refer to Meningitis Vaccine Information Sheet:

<http://www.cdc.gov/vaccines/Pubs/vis/downloads/vis-mening.pdf>

Please check one: Living on campus \_\_\_\_\_  
 Living off campus \_\_\_\_\_

- Quadrivalent conjugate (preferred)
  - a. Dose #1 \_\_\_/\_\_\_/\_\_\_      b. Booster \_\_\_/\_\_\_/\_\_\_      **OR**
- Quadrivalent polysaccharide (acceptable alternative)
  - a. Dose #1 \_\_\_/\_\_\_/\_\_\_      **OR**
- Waiver

I have received and reviewed the information provided by West Chester University regarding meningococcal disease. I am fully aware of the risks associated with meningococcal disease and the availability and effectiveness of the vaccination against the disease. I knowingly decided not to receive the vaccine against meningococcal disease for religious or other personal reasons. Please list: \_\_\_\_\_

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

**NOTE: Students under the age of 18 must secure the signature of their parent or guardian if they did not receive the meningitis vaccine and will reside in university housing.**

**EXEMPTION FROM REQUIRED IMMUNIZATIONS:**

- **MEDICAL** – Send letter to Student Health from health care provider explaining contraindications to specific vaccine(s).
  - **RELIGIOUS** – Send letter to Student Health from student explaining objection to vaccine(s).
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**The following immunizations are RECOMMENDED:**

**1. TETANUS** – Within 10 years of admission. Provide most recent date. A single dose of Tetanus, Diphtheria, Pertussis (Tdap) should be given to adolescents 11-18 and adults 19-64.

Booster: Tdap      \_\_\_/\_\_\_/\_\_\_  
    M D Y      **OR**

Booster: Td      \_\_\_/\_\_\_/\_\_\_  
    M D Y

**2. VARICELLA (Chicken Pox)**

(A history of chicken pox, a reactive varicella antibody titer, or two doses of vaccine for students born in the United States on or after 1980 meets this requirement.)

- History of disease: Date \_\_\_/\_\_\_/\_\_\_ **OR**  
    M D Y
- Varicella antibody titer drawn: \_\_\_/\_\_\_/\_\_\_      Reactive\_\_\_      Non-reactive\_\_\_      **OR**  
    M D Y

- Immunization
  - Dose #1      \_\_\_/\_\_\_/\_\_\_  
    M D Y
  - Dose #2 (given at least 12 weeks after the first dose ages 1-12 years, and at least 4 weeks after first dose if age 13 years or older)      \_\_\_/\_\_\_/\_\_\_  
    M D Y

**3. HEPATITIS B**

(Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or a Positive Hepatitis B surface antibody)

- Immunization (Hepatitis B)

#1 \_\_\_/\_\_\_/\_\_\_ #2 \_\_\_/\_\_\_/\_\_\_ #3 \_\_\_/\_\_\_/\_\_\_  
M D Y M D Y M D Y

OR

- Immunization (Combined Hepatitis A and B vaccine)

#1 \_\_\_/\_\_\_/\_\_\_ #2 \_\_\_/\_\_\_/\_\_\_ #3 \_\_\_/\_\_\_/\_\_\_  
M D Y M D Y M D Y

OR

- Date of Hepatitis B surface antibody: \_\_\_/\_\_\_/\_\_\_ Reactive \_\_\_ Non-reactive \_\_\_  
M D Y

**4. HPV (Human Papillomavirus Vaccine)**

(Three doses of vaccine for college students 11-26 years of age at 0, 1/2, and 6 month intervals.)

#1 \_\_\_/\_\_\_/\_\_\_ #2 \_\_\_/\_\_\_/\_\_\_ #3 \_\_\_/\_\_\_/\_\_\_  
M D Y M D Y M D Y

**5. Influenza Vaccine**

(One dose annually for all individuals over the age of 6 months. Provide most recent date.)

\_\_\_/\_\_\_/\_\_\_  
M D Y

**6. Other – Please list any other vaccines received with dates:**

\_\_\_\_\_  
\_\_\_\_\_

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**PART III: TUBERCULOSIS (TB) SCREENING**

Complete the Tuberculosis (TB) Screening Questionnaire attached. If you answer “yes” to any of the questions, you are required to provide documentation of a TB risk assessment within 6 months prior to the start of classes. Please contact the Student Health and Wellness Center at 610-436-2509 with questions or to schedule an appointment for testing. **\*A HISTORY OF BCG VACCINATION SHOULD NOT PRECLUDE TESTING OF A MEMBER OF A HIGH RISK GROUP.**

Medical Provider: Name \_\_\_\_\_ Signature \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Type of TB Test:  TB Skin Test (Mantoux) OR  Interferon Gamma Release Assay (IGRA)

Date of Test \_\_\_/\_\_\_/\_\_\_ Date of Reading \_\_\_/\_\_\_/\_\_\_  
M D Y M D Y

Negative \_\_\_\_\_ mm  Positive \_\_\_\_\_ mm

(Please give “mm” reading if Mantoux test performed.)

If Positive:

Chest X-ray: Date: \_\_\_\_\_ Results:  Negative  Positive

(Copy of Chest X-ray report must be attached)

If treated for TB, state date, duration and type of treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**By signing this document, I confirm that the information provided is accurate according to the best of my knowledge.**

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

**West Chester University**  
**Student Health and Wellness Center**  
**Tuberculosis (TB) Screening Questionnaire**

**Please answer the following questions:**

Have you ever had a positive TB skin test?  Yes  No

Have you ever had close contact with anyone who was sick with TB?  Yes  No

Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years? (If yes, please CIRCLE the country)  Yes  No

Have you ever traveled\* to/in one or more of the countries listed below? (If yes, please CHECK the country/ies)  Yes  No

Have you ever been vaccinated with BCG?  Yes  No

\* The significance of the travel exposure should be discussed with a health care provider and evaluated

Afghanistan	Cook Islands	Kazakhstan	Nigeria	Swaziland
Algeria	Cote d'Ivoire	Kenya	Pakistan	Syrian Arab Republic
Angola	Croatia	Kiribati	Palau	Tajikistan
Argentina	Democratic People's Republic of Korea	Kuwait	Panama	Thailand
Armenia	Democratic Republic of the Congo	Kyrgyzstan	Papua new Guinea	The former Yugoslav Republic of Macedonia
Azerbaijan	Djibouti	Lao People's Democratic Republic	Paraguay	Timor-Leste
Bahrain	Dominican Republic	Latvia	Peru	Togo
Bangladesh	Ecuador	Lesotho	Philippines	Tonga
Belarus	El Salvador	Liberia	Poland	Trinidad and Tobago
Belize	Equatorial Guinea	Libyan Arab Jamahiriya	Portugal	Tunisia
Benin	Eritrea	Lithuania	Qatar	Turkey
Bhutan	Estonia	Madagascar	Republic of Korea	Turkmenistan
Bolivia (Plurinational State of)	Ethiopia	Malawi	Republic of Moldova	Tuvalu
Bosnia and Herzegovina	French Polynesia	Malaysia	Romania	Uganda
Botswana	Gabon	Maldives	Russian Federation	Ukraine
Brazil	Gambia	Mali	Rwanda	United Republic of Tanzania
Brunei Darussalam	Georgia	Marshall Islands	Saint Vincent and the Grenadines	Uruguay
Bulgaria	Ghana	Mauritania	Sao Tome and Principe	Uzbekistan
Burkina Faso	Guam	Mauritius	Senegal	Vanuatu
Burundi	Guatemala	Micronesia (Federated States of)	Serbia	Venezuela (Bolivarian Republic of)
Cambodia	Guinea	Mongolia	Seychelles	Viet Nam
Cameroon	Guinea-Bissau	Montenegro	Sierra Leone	Yemen
Cape Verde	Guyana	Morocco	Singapore	Zambia
Central African Republic	Haiti	Mozambique	Solomon Islands	Zimbabwe
Chad	Honduras	Myanmar	Somalia	
China	India	Namibia	South Africa	
Columbia	Indonesia	Nepal	Sri Lanka	
Comoros	Iraq	Nicaragua	Sudan	
Congo	Japan	Niger	Suriname	