

**The following list is an aid to guide you with completing the health requirements. The deadline date is July 1, 2018.**

**REQUIRED HEALTH INFORMATION:**

**IMMUNIZATION RECORD OR COMPLETED FORM - Documentation must be provided in English.**

Dickinson College’s Pre-Admission Immunization Policy has been established to protect the health and well-being of the entire campus community. **All incoming students are required to submit immunization documentation that complies with the College’s requirements.** Your healthcare provider must complete and sign the [Immunization Record Form](#) or submit a copy of your immunization record. Statements such as “received as a child”, “records not available”, or “up to date” **ARE NOT ACCEPTABLE.** *Students who have not completed the immunization requirements will not be able to move in into their housing assignment directly upon arrival on campus.*

VACCINE REQUIRED	VACCINATION SCHEDULE	DOCUMENTATION REQUIRED
<b>Measles, Mumps, Rubella (MMR)</b>	Two doses of MMR at least 28 days apart after 12 months of age.	Provider-verified documentation of (MMR) vaccine dates <i>or</i> positive serologic test demonstrating immunity.
<b>Tetanus, Diphtheria, Pertussis (TDAP)</b>	One dose of Tdap regardless of interval since last Td booster.	Provider-verified documentation of vaccine date.
<b>Varicella</b>	Two doses of varicella vaccine at least 12 weeks apart if vaccinated between 1-12 years of age and at least 4 weeks apart if vaccinated at age 13 or older.	Provider-verified documentation of vaccine dates, history of illness, <i>or</i> positive serologic test demonstrating immunity. <i>Parental-verified history of illness is acceptable.</i>
<b>Meningococcal Quadrivalent</b>	Initial dose of conjugate vaccine: 11-12 years of age. Booster dose: If initial dose < 16 years.	Provider-verified documentation of vaccine date(s) or signed <u>waiver</u> .
<b>Hepatitis B</b>	Series of three age appropriate doses of vaccine (given at 0, 1-2 mo., and 6-12 mo) at any age. Alternatively, 2 adult doses (given at 0, and 4-6 mo.) if vaccinated between 11-15 years of age.	Provider-verified documentation of vaccine dates or positive serologic test demonstrating immunity

**TUBERCULOSIS RISK ASSESSMENT**

Tuberculosis risk assessment is required of all students, based upon guidelines of the American College Health Association and the CDC. The Tuberculosis Risk Assessment form must be completed by **both** student and health care provider. If the student meets the high-risk criteria, the following testing is required:  
 Previous negative TB testing: a tuberculin skin test (TST) is required. Previous positive TB testing or BCG inoculation: Interferon Gamma Release Assay (IGRA) or T-spot blood test report is required. If results are positive, then a chest x-ray report is also required.

**ONLINE MEDICAL HISTORY FORM – WELLNESS CENTER PATIENT PORTAL**

All students are required to complete the online medical history form located on the Wellness Center Patient Portal <https://dickinson.medicatconnect.com>.

**OPTIONAL HEALTH INFORMATION:**

**PHYSICAL EXAM/SUMMARY OF CARE**

A physical exam or summary of care is optional. You may submit a completed physical exam report or our [physical exam](#) form. It is also recommended that students with a chronic illness submit a summary of care from their specialist or primary care provider.

\_\_\_\_\_  
(Last Name, First Name)

\_\_\_\_\_  
Date of Birth

**Immunization Record Form**

- All information must be provided in English.
- Healthcare provider must complete and sign the immunization record form or submit a copy of the student's immunization record.
- Statements such as "received as a child", "records not available", or "up to date" **ARE NOT ACCEPTABLE**.

REQUIRED IMMUNIZATIONS	DATES (Month/Day/Year)	PENNSYLVANIA STATE REQUIREMENTS
MMR	#1 ____/____/____ #2 ____/____/____	2 doses of MMR (measles, mumps, and rubella), single component vaccines or positive titers. Minimum of 4 weeks between doses.  <b>1<sup>st</sup> vaccine dose cannot be given before 1<sup>st</sup> birthday.</b>
	Measles #1 ____/____/____ #2 ____/____/____	
	Mumps #1 ____/____/____ #2 ____/____/____	
Positive Titer	Rubella #1 ____/____/____ #2 ____/____/____	<b>ATTACH LAB REPORT</b>
	Measles ____/____/____	
	Mumps ____/____/____	

<b>Tdap</b>	Adult Tdap ____/____/____ (Adacel or Boostrix)	Tetanus, Diphtheria, Pertussis vaccine in the past 10 years. Tetanus/Diphtheria only vaccine is <b>not acceptable</b> .
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<b>Meningitis (quadrivalent)</b>	Menactra or Menveo ____/____/____	Meningitis A,C,Y,W-135 vaccine after the age of 16. <b>All students must provide proof of immunization or sign a waiver declining the meningitis vaccine in order to be housed on campus.</b>
	Booster (if indicated) ____/____/____ <a href="#">Meningitis Waiver</a> (click on link to download and sign)	

<b>Hepatitis B Series</b>	#1 ____/____/____ #2 ____/____/____ #3 ____/____/____ <input type="checkbox"/> pediatric dose or <input type="checkbox"/> adult dose	Series of 3 age appropriate doses (given at 0, 1-2 mo., and 6-12 mo.) at any age. Adolescents age 11-15 years can be given 2 adult doses (given at 0, and 4-6 mo)
<b>Hepatitis B Titer</b>	Hepatitis B Surface Antibody ____/____/____ <b>ATTACH LAB REPORT</b>	

<b>Varicella</b>	#1 ____/____/____ #2 ____/____/____	Health care provider documentation of immunization, history of disease, or positive titer.
	Date of Disease ____/____/____	
	Positive Titer Date ____/____/____ <b>ATTACH LAB REPORT</b>	2 doses of vaccine <b>at least 12 weeks apart if between the age of 1 and 12 years.</b>  2 doses of vaccine <b>at least 4 weeks apart if between the age 13 years or older.</b>

**HIGHLY RECOMMENDED VACCINES**

Hepatitis A Vaccine	#1 ____/____/____ #2 ____/____/____
HPV Vaccine	#1 ____/____/____ #2 ____/____/____ #3 ____/____/____
Meningitis B Vaccine	Bexsero or Trumemba #1 ____/____/____ #2 ____/____/____ #3 ____/____/____ (Trumemba)

Healthcare Provider Name or Office Stamp:		
_____ Print Name	_____ Signature	____/____/____ Date

## TUBERCULOSIS RISK ASSESSMENT

\_\_\_\_\_  
(Last Name, First Name)

\_\_\_\_\_  
Date of Birth

### Tuberculosis (TB) Risk Assessment – Student Questions

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Have you had close contact with persons known or suspected to have active TB disease?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Have you ever had a positive tuberculosis skin test or been vaccinated with BCG?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have you been a resident and/or employee of high-risk congregate settings?(correctional facilities, long-term care facilities, homeless shelters, health care facility)              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Have you been a member of any of the following groups that may have an increased incidence of tuberculosis disease? (medically underserved, low-income, or abusing drugs or alcohol) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Have you spent more than 1 month in any of the following endemic countries within the past 5 years?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Have you lived in any of the following endemic countries and arrived in the U.S. within the past 5 years?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### TABLE OF COUNTRIES ENDEMIC FOR TUBERCULOSIS

Afghanistan	Cambodia	Gabon	Latvia	Nauru	Sao Tome and Principe	Tuvulu
Algeria	Cameroon	Gambia	Lesotho	Nepal	Senegal	Uganda
Angola	Central African Republic	Georgia	Liberia	New Caledonia	Serbia	Ukraine
Anguilla	Chad	Ghana	Libya	Nicaragua	Seychelles	UR Tanzania
Argentina	China	Greenland	Lithuania	Niger	Sierra Leone	Uruguay
Armenia	China, Hong Kong SAR	Guam	Madagascar	Nigeria	Singapore	Uzbekistan
Azerbaijan	China, Macao SAR	Guatemala	Malawi	Northern Marian Islands	Solomon Islands	Vanuatu
Bangladesh	Colombia	Guinea	Malaysia	Pakistan	Somalia	Venezuela
Belarus	Comoros	Guinea-Bissau	Maldives	Palau	South Africa	Viet Nam
Belize	Congo	Guyana	Mali	Panama	South Sudan	Yemen
Benin	Cote d'Ivoire	Haiti	Marshal Islands	Papua New Guinea	Sri Lanka	Zambia
Bhutan	DPR Korea	Honduras	Mauritania	Paraguay	Sudan	Zimbabwe
Bolivia	DR Congo	India	Mauritius	Peru	Suriname	
Bosnia and Herzegovina	Djibouti	Indonesia	Mexico	Philippines	Swaziland	
Botswana	Dominican Republic	Iraq	Micronesia	Portugal	Syrian Arab Republic	
Brazil	Ecuador	Kazakhstan	Mongolia	Qatar	Tajikistan	
Brunei Darussalam	El Salvador	Kenya	Montenegro	Rep Korea	Thailand	
Bulgaria	Equatorial Guinea	Kiribati	Morocco	Republic of Moldova	Timore-Leste	
Burkina Faso	Eritrea	Kuwait	Mozambique	Romania	Togo	
Burundi	Ethiopia	Kyrgyzstan	Myanmar	Russian Federation	Tunisia	
Cabo Verde	Fiji	Lao PDR	Namibia	Rwanda	Turkmenistan	

### TB Risk Assessment – Provider Questions

1. Has the student ever had a positive tuberculin skin test (TST, formerly PPD) or Quantiferon TB test?  Yes  No
2. Does the student have a medical condition associated with increased risk of progressing to TB disease?  Yes  No
3. Is the student a member of a high risk group?  Yes  No

**If answered NO to all above answers, student does not meet high-risk criteria and further testing is not needed. If answered yes to any of the above questions, the student does meet high-risk criteria and is required to undergo tuberculosis screening.**

### TUBERCULOSIS SCREENING (Date of screening must be within the past 6 months):

Does the student have signs or symptoms of active tuberculosis disease such as unexplained elevation of temperature for more than one week, weight loss, night sweats, persistent cough for more than three weeks or cough with production of bloody sputum (hemoptysis)?

Yes  No

If NO, proceed to tuberculosis testing. If YES, provide documentation of evaluation to exclude active tuberculosis disease, including tuberculosis testing, chest x-ray, and sputum evaluation, as indicated.

Previous Negative Tuberculosis Testing:

**Tuberculin Skin Test (TST):** TST results must be read in 48-72 hours following the test and should be record as actual millimeters (MM) of Induration, transverse diameter; if no induration, write "0".

Date Placed \_\_\_\_\_ Date Read \_\_\_\_\_ Results: \_\_\_\_ mm

Previous Positive Tuberculosis Testing or BCG Inoculation:

**Quantiferon Test (QFT) or T-Spot blood test:** A copy of the lab report must be provided in English.

Date obtained \_\_\_\_\_ Results:

**If testing is positive, a chest x-ray is required and a report must be provided in English.**

\_\_\_\_\_  
Provider Name

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number