

Dear Future Laker,

Welcome to Mercyhurst University. We look forward to you joining our campus in the fall. In order to ensure the health and wellbeing of our students, the enclosed health record forms are required from all incoming students (freshman and transfer students) by **July 21, 2016**. Students planning to reside in campus housing during summer 2016 for a summer program or athletic team must provide health record forms **prior to their summer move-in**. The following forms are required:

- **Sections I to IV**, to be completed by the student.
- **Sections V to VII**, to be completed, signed and dated by the health care provider. These sections include the results of a physical examination conducted within one year of the start date at Mercyhurst, a TB assessment and immunization record.
- A **meningitis waiver** is required ONLY from students who have chosen not to receive a meningitis vaccine due to religious, medical or other reasons. The waiver is available on the Cohen Health Center page of the university portal at my.mercyhurst.edu (click on "Wellness and Resources"). Under Pennsylvania law, a student cannot move into campus housing without evidence of a vaccine or a signed waiver on file.

Student-athletes must submit these health record forms in addition to any health records required by their athletics program.

Immunizations are not provided on campus, so please be sure they are up to date prior to coming to Mercyhurst. The Advisory Council on Immunization Practices (ACIP) also recommends the HPV vaccine Gardasil; please talk with your health care provider about this three-inoculation series available for men and women.

Allergy shots can, in most cases, be provided on campus. For information and forms, visit the Cohen Health Center page of the university portal at my.mercyhurst.edu (click on "Wellness and Resources").

Meningitis: Pennsylvania law requires that all students who will be living in campus housing and who are age 25 or younger must submit proof of one dose of meningococcal conjugate vaccine that covers serogroups A, C, Y and W-135. ACIP recommends that adolescents who receive their first dose at age 13-15 should receive a booster dose at age 16-18.

International students: the meningitis vaccine administered outside the U.S. may not cover A, C, Y and W-135, which are the most common strains in the U.S. Please consult your physician to ensure that these strains are covered in order to avoid requiring additional immunization upon your arrival to the U.S.

Please return these completed forms to the Cohen Health Center either by faxing them to 814-824-2242 or mailing them to:

Mercyhurst University Cohen Student Health Center
501 E. 38th Street
Erie, PA 16546

If you have any questions, please contact the Cohen Health Center at health@mercyhurst.edu or call 814-824-2431, Monday through Friday, 8:30 a.m. to 4 p.m. Thank you for your cooperation, and we look forward to seeing you on campus.

Sincerely,

Judy Smith, Ph.D.
Executive Director of Wellness
Cohen Student Health Center, Mercyhurst University

SECTIONS V (Physical Examination), VI (TB Assessment), and VII (Immunization History) are to be completed by the physician (or NP/PA). Each section requires a signature and date.

Please return this completed packet to the student/family. If you are asked to return this directly to Mercyhurst, send it to:

Mercyhurst University, Cohen Student Health Center
501 East 38th Street • Erie, PA 16546 | 814-824-2037 or 814-824-2431 or via fax: 814-824-2242

V. PHYSICAL EXAMINATION - THIS SECTION TO BE COMPLETED BY PHYSICIAN (OR NP/PA)

Name of Applicant: _____ Height: _____ Weight: _____ Blood Pressure: _____

Eyes: R 20/ _____ L 20/ _____ Normal _____ Abnormal _____

Ears: Canal Normal _____ Canal Abnormal _____ T.M. Normal _____ Abnormal _____

Tonsils (Circle one): Present / Absent

Have you ever had "Strep Throat"? (Circle one) Y / N If yes, date: _____ Rx: _____

Mouth (Circle one for each): Tongue Normal / Abnormal Teeth Normal / Abnormal

Spine (Circle one): Normal / Abnormal / Lordosis / Scoliosis

Skin (Circle all that apply): Normal / Abnormal / Piercing Sites / Tattoos

Lungs (Check if true): _____ Clear to percussion and auscultation

Thyroid (Circle one): Normal / Abnormal Lymph Nodes (Circle one): Normal / Abnormal

Heart Rate: _____ Rhythm: _____ PMI: _____ S1 & S2: _____

Extra Sounds: _____ Murmurs: _____

Abdomen (Circle one): Normal / Abnormal Inguinal Area (Circle one): Normal / Abnormal

C.N.S. (Circle one): Normal / Abnormal

Does this student have any condition that would interfere with activities? Y / N

If yes, please specify: _____

Recommendation: _____

Date of Examination: _____ (Must be completed within 12 months of the start of the upcoming college year)

MD, DO, NP or PA Signature: _____ Printed Name: _____

VI. TUBERCULOSIS (TB) SCREENING/TESTING¹

Name of Applicant: _____

HEALTHCARE PROVIDER: PLEASE ASK THE STUDENT THE SIX QUESTIONS BELOW TO DETERMINE IF TB TESTING IS INDICATED:

- 1.) Have you ever had close contact with persons known or suspected to have active TB disease? Yes / No
- 2.) Were you born in one of the countries listed below that have a high incidence of active TB disease? Yes / No (If yes, please circle the country below)

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2012. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to <http://apps.who.int/ghodata>

- 3.) Have you had frequent or prolonged visits* to one or more of the countries listed above with a high prevalence of TB disease? (If yes, CHECK the countries above.)
- 4.) Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?
- 5.) Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease?
- 6.) Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol?

If the answer is YES to any of the above questions, Mercyhurst University requires TB testing prior to starting at the University (see below).

If the answer to all of the above questions is NO and there are no current active signs of TB that might require additional evaluation (#1 below), no testing or further action is required (sign TB form on page 6, and then proceed to Immunization History form on page 7).

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

Name of Applicant: _____

1.) Tuberculosis (TB) Risk Assessment (To Be Completed By Health Care Provider)

Is there a history of a positive TB skin test or IGRA blood test? (If yes, document below) Yes / No

Is there a history of BCG vaccination? (If yes, consider IGRA if possible) Yes / No

If the student answered YES to any of the six questions on the prior page,, the student should receive either the Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) at this time (provided that you did not answer “yes” to any of the questions above regarding a previous positive TB test).

Please be certain to also consider whether there are any current active signs of TB that might require additional evaluation (#1 below)

2.) TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes / No

If No, proceed to either the TST (#2) or IGRA (#3)

If Yes, check below and proceed with additional evaluation as indicated including tuberculin skin testing, chest x-ray, and sputum evaluation.

- Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- Coughing up blood (hemoptysis)
- Chest pain
- Loss of appetite
- Unexplained weight loss
- Night sweats
- Fever

3.) Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write “0”. The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ___/___/___ Date Read: ___/___/___
 M D Y M D Y

Result: _____ mm of induration **Interpretation: positive ___ negative ___

**Interpretation guidelines

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equiv-alent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

>10 mm is positive:

- recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings

Name of Applicant: _____

- Persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunioleal bypass and weight loss of at least 10% below ideal body weight.

>15 mm is positive:

- Persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

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

4.) Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/____/____ (Specify Method, Circle one) QFT-GIT / T-Spot / Other _____

Result (Circle one): Negative / Positive / Indeterminate / Borderline (T-Spot only)

Date Obtained: ____/____/____ (Specify Method, Circle one) QFT-GIT / T-Spot / Other _____

Result (Circle one): Negative / Positive / Indeterminate / Borderline (T-Spot only)

5.) Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: ____/____/____

Result (Circle one): Negative / Abnormal

Management of Positive TST or IGRA

All students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- Infected with HIV
- Recently infected with M. tuberculosis (within the past 2 years)
- History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- Have had a gastrectomy or jejunioleal bypass
- Weigh less than 90% of their ideal body weight
- Cigarette smokers and persons who abuse drugs and/or alcohol

•• Populations defined locally as having an increased incidence of disease due to M. tuberculosis, including medically underserved, low-income populations

- Student agrees to receive treatment
- Student declines treatment at this time

HEALTH CARE PROVIDER

Name: _____

Signature: _____

Address: _____

Phone: _____

This section is to be completed and signed by your Health Care Provider.
All information must be in English.

VII. IMMUNIZATION RECORD

Name in Full (First Middle Last): _____

Age: _____ Date of Birth: _____

A. MMR (MEASLES, MUMPS, RUBELLA) - two doses required at least 28 days apart for students born after 1956 and all health care professional students.

1. Dose 1 given at age 12 months or later. #1 ____/____/____

2. Dose 2 given at least 28 days after first dose. #2 ____/____/____

B. POLIO - Primary series, doses at least 28 days apart. Three primary series are acceptable. See ACIP website for details.

1. OPV alone (oral Sabin three doses): #1 ____/____/____ #2 ____/____/____ #3 ____/____/____

2. IPV/OPV sequential: IPV #1 ____/____/____ IPV #2 ____/____/____

OPV #3 ____/____/____ OPV #4 ____/____/____

3. IPV alone (injected Salk four doses): #1 ____/____/____ #2 ____/____/____ #3 ____/____/____ #4 ____/____/____

C. VARICELLA - Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement.

1. History of Disease Yes ___ No ___ or Birth in U.S. before 1980 Yes ___ No ___

2. Varicella antibody ____/____/____ Result: Reactive _____ Non-reactive _____

3. Immunization Dose #1 ____/____/____

Dose #2 ____/____/____

(Dose #2 should be given at least 12 weeks after first dose ages 1-12 years and at least 4 weeks after first dose if age 13 years or older.)

D. TETANUS, DIPHTHERIA, PERTUSSIS

1. Primary series completed? Yes ___ No ___ Date of last dose in series: ____/____/____

2. Date of most recent booster dose: ____/____/____

Type of booster: Td ___ Tdap ___ *Tdap booster recommended for ages 11-64 unless contraindicated.

E. HUMAN PAPILLOMAVIRUS VACCINE - HPV2 or HPV4 or HPV9 (females and males, ages 9-26, three doses at 0, 1-2, and 6 month intervals.)

Immunization (indicate which preparation) HPV2 ___ or HPV4 ___ or HPV9 ___

a. Dose #1 ____/____/____ b. Dose #2 ____/____/____ c. Dose #3 ____/____/____

F. INFLUENZA

Date of last dose: ____/____/____

Trivalent inactivated influenza vaccine (TIV) ___ Live attenuated influenza vaccine (LAIV) ___

Name of Applicant: _____

G. HEPATITIS A

1. Immunization (hepatitis A) a. Dose #1 ___/___/___ b. Dose #2 ___/___/___
2. Immunization (Combined hepatitis A and B vaccine) a. Dose #1 ___/___/___ b. Dose #2 ___/___/___ c. Dose #3 ___/___/___

H. HEPATITIS B - All college and health care professional students. Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or a positive hepatitis B surface antibody meets the requirement.

1. Immunization (hepatitis B)

- a. Dose #1 ___/___/___ Adult formulation ___ Child formulation ___
b. Dose #1 ___/___/___ Adult formulation ___ Child formulation ___
c. Dose #1 ___/___/___ Adult formulation ___ Child formulation ___

2. Immunization (Combined hepatitis A and B vaccine)

3. Hepatitis B surface antibody

Date ___/___/___ Result: Reactive ___ Non-reactive ___

I. PNEUMOCOCCAL POLYSACCHARIDE VACCINE - One dose for members of high-risk groups.

Date ___/___/___

J. MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135) **ACIP recommends that adolescents who receive their first dose at age 13 through 15 years should receive a booster dose at age 16 through 18 years.

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible). a. Dose #1 ___/___/___ b. Dose #2 ___/___/___
2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available). Date ___/___/___

K. MENINGITIS B - OPTIONAL A second meningitis vaccine to protect against Meningitis B has been released.

Students are not required to receive the Meningitis B vaccine. However, if the student has received it, please complete the following information:

Vaccine Name: _____

- a. Dose #1 ___/___/___ b. Dose #2 ___/___/___ c. Dose #3 ___/___/___

MD, DO, NP or PA Signature: _____ Phone #: _____

PRINTED NAME: _____



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