Student Name: ____

Tompkins Cortland Community College
PO Box 139, Dryden, New York 13053
fax: 607.844.6533 | phone: 607.844.8222, Ext. 4487

Health Services Immunization and Health Information Form

Your complete record for required vaccines (Part II) must be on file in our Health Center before the start of classes or you will be MEDICALLY WITHDRAWN FROM CLASSES per NYS Public Health Laws 2165 and 2167. Please contact Health Services with any questions. (607.844.8222, Ext.4487) or refer to our website for further information: https://www.tompkinscortland.edu/campus-life/health-center

PART I: TO BE COMPLETED BY STUDENT

Name ______________________ ______________________ ______________________
First Name Middle Name Last Name

Address ____
Street City S tate Zip

Semester/year of enrollment ___/______ Date of Birth ___/___/______ School ID# ______________________
M Y M D Y

PART II: TO BE COMPLETED BY PARENT IF STUDENT IS UNDER 17 YEARS OLD:

STUDENT TREATMENT PERMISSION

I grant permission for Tompkins Cortland Community College Health Services to provide medical care and immunizations to the above student as necessary.

Parent/Guardian Signature ______________________________________ Date ______________

PART III: TO BE COMPLETED BY STUDENT IF DECLINING MENINGITIS VACCINE

All information must be in English.

Declination: (acceptable)

If the student/parent declines the meningococcal vaccine, a signature is needed:

I have decided to decline the Meningitis vaccine by signing below. I have read, or have had explained to me the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine.

Student signature: ______________________________________ Date______________

(Parent os guardian signature if student under 18 years of age)

REQUIRED IMMUNIZATIONS

A. MMR (MEASLES, MUMPS, RUBELLA) (Two doses required at least 28 days apart for students born after 1957.)

1. Dose 1 given at age 12 months or later . ... #1 Date ____________

2. Dose 2 given at least 28 days after first dose . ... #2 Date ____________

or

Positive antibodies for Measles, Mumps, and Rubella. **ATTACH COPY OF LAB RESULTS**

B. MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135) One dose within the last 5 years or a completed 2-dose series. (Not required if above declination is signed)

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).

a. Dose #1 Date ____________ b. Dose #2 Date ____________

2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available).

Provider signature ______________________________________ Date ______________

C. TETANUS, DIPHTHERIA, PERTUSSIS

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1. Date of last dose in series: ___/___/______
M D Y

2. Date of most recent booster dose: ___/___/______ Type of booster: Td ____ Tdap ____

Tdap booster recommended for ages 11-64 unless contraindicated
M D Y

D. VARICELLA (A positive varicella antibody or two doses of varicella vaccine)
1. Positive varicella antibody. ATTACH COPY of LAB RESULTS
2. Immunization
a. Dose #1 . ... #1 ___/___/______
M D Y
b. Dose #2 given at least 12 weeks after first dose ages 1–12 years.. #2 ___/___/______
and at least 4 weeks after first dose if age 13 years or older.
M D Y

PART IV. TUBERCULOSIS (TB) SCREENING/TESTING1

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? ☐ Yes ☐ No

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease?
(If yes, please CIRCLE the country, below) ☐ Yes ☐ No

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

Have you had frequent or prolonged visits* to one or more of the countries or territories listed above with a high prevalence of TB disease?
(If yes, CHECK the countries or territories, above) ☐ Yes ☐ No

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?
☐ Yes ☐ No

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? ☐ Yes ☐ No

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? ☐ Yes ☐ No

If the answer is YES to any of the above questions, Tompkins Cortland Community College requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester. **THIS MUST BE DONE BY YOUR HEALTH CARE PROVIDER**.

If the answer to all of the above questions is NO, no further testing or further action is required.

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

TUBERCULOSIS (TB) RISK ASSESSMENT (to be completed by health care provider)

Clinicians should review and verify the information above. Persons answering YES to any of the questions in Part M are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below) ☐ Yes ☐ No

History of BCG vaccination? (If yes, consider IGRA if possible.) ☐ Yes ☐ No

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1. TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? ☐ Yes ☐ No If No, proceed to 2 or 3

If yes, check below:

☐ 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

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. 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___

Date Given: ___/___/___ Date Read: ___/___/___
M D Y M D Y
Result: _______ mm of induration **Interpretation: positive___ negative___

3. Chest x-ray: (REQUIRED IF TST OR IGRA IS POSITIVE)

Date of chest x-ray: ___/___/___ Result: normal___ abnormal____
M D Y

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 jejunoileal 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 (_________) ____