Saint Martin's UNIVERSITY

STUDENT IMMUNIZATION HISTORY & EMERGENCY INFORMATION

Name _____ _____
First Name Last Name Primary Phone Number

Address_____
Street City State Zip

Date of Birth ____/____/_____ Gender (check one): Male___Female___Trans ___Starting Semester and Year _____
M D Y

SMU ID #___SMU email address_____

Status: Freshman _____ Transfer _____ Graduate _____ International _____ Country_____

The following information will be used for emergency use only:

Emergency contact name and phone number_____

Please complete as applicable. Use the back of the form if necessary.

Medical History_____ _____
Allergies Medications

_____
Medical Concerns/Previous Surgeries

A COPY OF YOUR IMMUNIZATION RECORD(S)IS ALSO REQUIRED

University students are at greater risk for contracting a variety of diseases. Saint Martin's University follows immunization requirement recommendations from the Center for Disease Control (www.cdc.gov), the American College Health Association (www.acha.org) and state and local Public Health Departments. Exemption inquiries please email healthcenter@stmartin.edu. The requirements apply to all new undergraduate and graduate students born on or after January 1, 1957. **To meet the requirements, please complete and sign this form and attach your immunization records.**
The MMR and MCV vaccines may be obtained at the SMU Student Health Center upon request for a fee.

REQUIRED IMMUNIZATION FOR ALL STUDENTS (nursing students, please use nursing forms)

OPTION 1: MMR (MEASLES, MUMPS, RUBELLA) **Copy of record must be attached**
(Two doses required at least 28 days apart for students born after 1956 and all health care professional students.)

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

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

OPTION 2: Documented proof that you have had a positive measles (rubeola) antibody test. **Attach copy of results.**

Date of Test ____/__/_____

REQUIRED IMMUNIZATION FOR ALL STUDENTS LIVING ON CAMPUS

MENINGOCOCCAL QUADRIVALENT (MCV or MCV4) **Copy of record must be attached**
(A, C, Y, W-135) One dose within the last 5 years **for all college students living in the residence halls** – revaccinate every 5 years

1. Quadrivalent polysaccharide (Menveo or Menactra)

Date ____/____/_____

RECOMMENDED IMMUNIZATIONS (not currently required)

Current COVID booster, Current FLU vaccine, POLIO series, VARICELLA series
TETANUS, DIPHTHERIA, PERTUSSIS(Tdap) within the last 10 years
HUMAN PAPILLOMAVIRUS VACCINE series (GARDASIL 9),MENINGOCOCCAL B (Men B)
HEPATITIS A series, HEPATITIS B series, PNEUMOCOCCAL POLYSACCHARIDE VACCINE

Saint Martin's University Health Center Consent and Decree
THIS DOCUMENT HAS LEGAL SIGNIFICANCE. PLEASE READ CAREFULLY

Saint Martin's University will keep your medical records confidential to the extent allowed by law and the records will only be used for the provision of health care services. You, as the student, must inform Residence Hall staff or other University personnel (i.e. physical education instructors or athletic coaches) of any medical condition that you have that could be of concern while you are attending SMU. Furthermore, you are responsible for wearing a MedicAlert bracelet, necklace or similar device to warn health care providers of your diabetes, hemophilia, heart disease, seizure disorder, drug allergies, or other significant medical conditions.

In the event SMU is required to rely on this consent to authorize necessary medical care and treatment for the student, the undersigned, individually and jointly, agree to indemnify and hold SMU harmless for the costs incurred for said emergency care and treatment, including reasonable attorney fees and costs incurred in defending and/or instituting a suit to recover said medical expenses.

Forms MUST be completed fully and accurately with necessary documentation attached and be on record at the Student Health Center or a HOLD will be placed on the student's account after the last day of the add/drop period.

As an SMU student, I consent to any medical or surgical treatment in the event of a medical emergency as confirmed by an attending physician or other medical professional at the SMU Student Health Center. If I am under 18 years of age, SMU will attempt to contact the undersigned parent or guardian for approval before relying on this consent. In addition, I must personally consent to said medical procedures if I am physically and emotionally capable of consenting at the time such treatment is required.

I declare, under penalty of perjury under laws of the State of Washington, that the foregoing is true and correct.

SIGNATURE **Printed name** **DATE**
(Please SIGN and PRINT your name)

PARENT OR GUARDIAN SIGNATURE **Printed name** **DATE**
(Required only if student is under 18 years of age at time of signing)

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Name _____ _____
First Name Last Name

Starting Semester and Year_____ Date of Birth ____/____/_____ Class (circle one): ESL Undergraduate Graduate
M D Y

Part I: Tuberculosis (TB) Screening Questionnaire (to be completed by students who were born or have lived extensively outside the contiguous United States)

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 listed below that have a high incidence of active TB disease? (If yes, please write the country here_____) ❑ 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
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo (Democratic Republic of)
Côte d'Ivoire
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Korea (Democratic People's Republic of)
Korea (Republic of)
Kyrgyzstan
Lao People's Democratic Republic
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mexico
Micronesia (Federated States of)
Moldova (Republic of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Qatar
Romania
Russian Federation
Rwanda
Sao Tome
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
Tanzania (United Republic of)
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.

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) ❑ Yes ❑ No

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

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 one or more of the above questions, please visit your medical provider to take a TB test and ask them to complete the rest of the form. Please send the TB test results with the forms. If you have had a TB test within the last 6 months you can submit your recent test results.

If you answered, **NO** to all of the above questions, you are complete.

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

Name _____ _____
First Name Last Name

Part II. Clinical Assessment by Health Care Provider

Clinicians should review and verify the information in Part I. Persons answering YES to any of the questions in Part I 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[1]

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 Tests (TST) *Please note* Two TST tests, one week apart, are required if using TST option. (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____

****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 equivalent 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
- 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 jejunoileal 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.

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Name _____ _____
First Name Last Name

[1] CDC. Controlling Tuberculosis in the United States: Recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America. MMWR November 2005; 54 (No. RR-12): 4-5.

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/____/____ (specify method) QFT-GIT T-Spot other_____
M D Y

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

Date Obtained: ____/____/____ (specify method) QFT-GIT T-Spot other_____
M D Y

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

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

Date of chest x-ray: ____/____/____ Result: normal____ abnormal_____
M D Y

Part III. 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 Professional Signature Date

Students: Completed forms are to be emailed to: healthcenter@stmartin.edu