Pennsylvania College of Technology
A Penn State Affiliate

International Student Immunization Verification Form

College Health Services

Upload the completed Immunization Verification Form and all other related documents through myHealth Online at pct.medicatconnect.com.

PART I

Name _____
First name *Middle name* *Last name*

_____
Street address / box number / apartment *City* *State* *ZIP code*

Date of birth _____/_____/_____ PCT ID# _____ Status: ☐ Part-time ☐ Full-time
MM DD YYYY

Tuberculosis (TB) Screening/Testing[1]

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? ☐ Yes ☐ No

(If yes, please circle the country below)

☐ Afghanistan
☐ Algeria
☐ Angola
☐ Argentina
☐ Armenia
☐ Azerbaijan
☐ Bahrain
☐ 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
☐ 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
☐ Gabon
☐ Gambia
☐ Georgia
☐ Ghana
☐ 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
☐ Morocco
☐ Mozambique
☐ Myanmar
☐ Namibia
☐ Nauru
☐ Nepal
☐ Nicaragua
☐ Niger
☐ Nigeria
☐ Niue
☐ 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
☐ Turkey
☐ 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 listed above with a high prevalence of TB disease? ☐ Yes ☐ No

(If yes, check the countries above)

** The significance of the travel exposure should be discussed with a healthcare 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 healthcare 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, Pennsylvania College of Technology requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester.

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

[1]The American College Health Association has published guidelines on "Tuberculosis Screening and Targeted Testing of College and University Students." To obtain the guidelines, visit www.acha.org.

PART II: To be completed and signed by your healthcare provider. All information must be in English.

Required vaccinations

A. MMR (Measles, Mumps, Rubella)

Dose #1 _____/_____/_____ (MM DD YYYY) Dose #2 _____/_____/_____ (MM DD YYYY)

B. Meningococcal Quadrivalent Required for all on-campus residents; strongly recommended for all other students.

(A, C, Y, W-135) One or two doses for all college students; revaccinate every 5 years.

1. Quadrivalent conjugate

Dose #1 _____/_____/_____ (MM DD YYYY) Dose #2 _____/_____/_____ (MM DD YYYY)

C. Tetanus, Diphtheria, Pertussis Tdap booster must be within the last 10 years

1. Primary series completed? ☐ Yes ☐ No Date of last dose in series _____/_____/_____ (MM DD YYYY)
2. Date of most recent booster dose _____/_____/_____ (MM DD YYYY) Type of booster ☐ Td ☐ Tdap

D. Hepatitis B

Dose #1 _____/_____/_____ (MM DD YYYY) Dose #2 _____/_____/_____ (MM DD YYYY) Dose #3 _____/_____/_____ (MM DD YYYY)

E. Varicella

1. History of disease ☐ Yes ☐ No
2. Immunization Dose #1 _____/_____/_____ (MM DD YYYY) Dose #2 _____/_____/_____ (MM DD YYYY)

F. Tuberculosis (TB) Risk Assessment (completed by healthcare provider)

Clinicians should review and verify the information above. Persons answering yes to any of the questions in Part F 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 TST or IGRA blood test? (If yes, document below) ☐ Yes ☐ No

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

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) ☐ Loss of appetite ☐ Night sweats

☐ Chest pain ☐ Unexplained weight loss ☐ Fever

Proceed with additional evaluation to exclude active tuberculosis disease including TST, 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 _____/_____/_____ (MM DD YYYY) Date read _____/_____/_____ (MM DD YYYY)

Result _____ mm of induration **Interpretation ☐ positive ☐ negative

Date given _____/_____/_____ (MM DD YYYY) Date read _____/_____/_____ (MM DD YYYY)

Result _____ mm of induration **Interpretation ☐ positive ☐ negative

3. Interferon Gamma Release Assay (IGRA)

Date obtained _____/_____/_____ (MM DD YYYY) (specify method) ☐ QFT-GIT ☐ T-Spot ☐ other_____

Result ☐ negative ☐ positive ☐ indeterminate ☐ borderline ☐ (T-Spot only)

Date obtained _____/_____/_____ (MM DD YYYY) (specify method) ☐ QFT-GIT ☐ T-Spot ☐ other_____

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
MM DD YYYY

**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 (e.g., 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.

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

Strongly recommended vaccines

G. Influenza

Date of last dose _____/_____/_____
MM DD YYYY

H. Human Papillomavirus Vaccine (HPV2/HPV4/HPV9)

Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____
MM DD YYYY MM DD YYYY MM DD YYYY

I. HEPATITIS A

Dose #1 _____/_____/_____ Dose #2 _____/_____/_____
MM DD YYYY MM DD YYYY

J. Meningococcal Serougroup B (two or three dose series)

MenB-RC (Bexsero) ☐ routine ☐ outbreak –related

Dose #1 _____/_____/_____ Dose #2 _____/_____/_____
MM DD YYYY MM DD YYYY

OR

MenB-FHbp (Trumenba) __routine ___outbreak-related

Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____
MM DD YYYY MM DD YYYY MM DD YYYY

Healthcare Provider

Name_____ Signature_____

Address _____ Phone_____

Provider: Provide this completed form and a copy of any immunizations to the student.