PENN COLLEGE HEALTH SERVICES

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INTERNATIONAL STUDENT IMMUNIZATION VERIFICATION FORM

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

PART I

Name _____
First (given) name Middle name Last (family) name

_____
Street address / box number / apartment

_____
City Province or state Postal code Country

Date of Birth ____/____/_____ PCT ID# _____
MM DD YYYY

Status: Part-time _____ Full-time _____

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 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 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.

_____

PART II: TO BE COMPLETED AND SIGNED BY YOUR MEDICAL PROVIDER. ***All information must be in English.***

REQUIRED VACCINATIONS

A. MMR (MEASLES, MUMPS, RUBELLA)

a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____
MM DD YYYY 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 2 doses for all college students; revaccinate every 5 years.

1. Quadrivalent conjugate

a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____
MM DD YYYY 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: ____/____/_____ Type of booster: Td _____ Tdap _____
MM DD YYYY

D. HEPATITIS B

a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____
MM DD YYYY MM DD YYYY MM DD YYYY

E. VARICELLA

1. History of Disease Yes ___ No ___

2. Immunization

a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____
MM DD YYYY MM DD YYYY

F. TUBERCULOSIS (TB) RISK ASSESSMENT (completed by medical 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 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** _____

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: ____/____/____
MM DD YYYY MM DD YYYY

Result: _____ mm of induration **Interpretation: positive____ negative____

Date Given: ____/____/____ Date Read: ____/____/____
MM DD YYYY MM DD YYYY

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 (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

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

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/____/____ (specify method) QFT-GIT T-Spot other_____
MM DD YYYY
Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

Date Obtained: ____/____/____ (specify method) QFT-GIT T-Spot other_____
MM DD YYYY
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

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

F. INFLUENZA

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

G. HUMAN PAPILLOMAVIRUS VACCINE (HPV2/HPV4/HPV9)

a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____
MM DD YYYY MM DD YYYY MM DD YYYY

H. HEPATITIS A

a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____
MM DD YYYY MM DD YYYY

I. MENINGOCOCCAL SEROUGROUP B (Two or three dose series)

1. MenB-RC (Bexsero) __ routine ____outbreak –related

a. Dose #1____/____/_____ b. Dose #2. ____/____/_____
MM DD YYYY MM DD YYYY

OR

1. MenB-FHbp (Trumenba) __routine ___outbreak-related

a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____
MM DD YYYY MM DD YYYY MM DD YYYY

MEDICAL PROVIDER

Name _____ Signature _____

Address _____ Phone (_____) _____

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