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 well-being of our students, timely return of the enclosed Health Record, and proof of meningitis and Measles-Mumps-Rubella vaccines, is required from all incoming students (freshman, transfer students, and incoming graduate students) as soon as possible and no later than June 15, 2020. New incoming students planning to move during summer must have documentation submitted ahead of that time.

Preadmission Health Record. Sections I to IV, to be completed by the student. Sections V (physical examination), VI (TB screening/testing) and VII (immunization history) to be completed, signed and dated by the health care provider.

**Student Athletes** must submit these health record forms directly to the Cohen Student Health Center. Additional health records required by their athletic programs should be directed to Athletics.

**Required immunizations** include meningitis and Measles-Mumps-Rubella. Mercyhurst requires that all students provide proof of two documented doses of the Measles-Mumps-Rubella (MMR) vaccine with the first time being administered on, or no sooner than, the first birthday and the second dose at least one month later, OR by submitting a lab test (“titer”) documenting immunity. Pennsylvania law also requires that any student living in campus-owned housing provide proof of one does of meningococcal conjugate vaccine before being permitted to move on campus.

Students not providing the completed Health Record form and evidence (or waiver) of required vaccines may not register for classes until signed forms are provided. Students without proof of a meningitis vaccine may not move into university housing unless a waiver is in place (forms available at mercyhurst.edu/vaccines).

**Strongly recommended immunizations** include: tetanus-diphtheria-pertussis (Tdap), polio, varicella (chicken pox), hepatitis A and hepatitis B, human papillomavirus (HPV), and meningococcal B. Pneumococcal vaccine for students with certain medical risk factors may be indicated. Mercyhurst and the CDC strongly recommend that students who received a meningococcal vaccine three or more years prior to coming to campus receive an additional one before arrival.

**International Students**: the meningitis vaccine administered outside the U.S. often does not protect against serogroups A, C, Y, and W135 (four of the five most common U.S. strains). Students should consult their physician, and if a vaccine targeting these serogroups does not exist at home, the students will obtain the vaccine upon arrival to the U.S. before moving into campus housing.

**TB tests**: Any new incoming student, including commuters and those living on campus, with a positive answer to any question on the TB screening interview, including country of origin, must have a TB test and any indicated follow-up prior to coming to campus. Students with no positive answers to the screening questions are not required to have a TB test.

**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 mercyhurst.edu/allergies.

Please return these completed forms to the Cohen Health Center either by faxing them to 814-347-8275 or mailing them to:

Mercyhurst University Cohen Student Health Center  
501 East 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
I. Name in Full: ____________________________ Sex: ____________________________
Home Address: ____________________________ City: ____________________________ State: ____________________________ Zip Code: ____________________________
Home Phone: ____________________________ Student Cell Phone: ____________________________
Age: ____________________________ Date of Birth: ____________________________
Name of Parents/Spouse: ____________________________
Insurance Company: ____________________________ Policy #: ____________________________
Student’s email address: ____________________________

II. In case of illness/emergency, please notify: ____________________________
Relationship to Student: ____________________________ Phone #: ____________________________
Home Address: ____________________________
☐ I authorize the medical service of Mercyhurst University to provide appropriate treatment for any illness or injury.

Student Signature ____________________________ Parent/Guardian Signature (if student is under 18 years of age) ____________________________ Date ____________________________

III. List all known allergies to medications, foods and/or environmental allergens: ____________________________
List any illness, injury or surgery you have had: ____________________________
List any health problems or chronic illnesses you presently have: ____________________________
Are you presently under a physician’s care? (Circle one) Yes / No
If so, list any medications you are currently taking: ____________________________
Do you take allergy shots (Circle one) Yes / No
If so, and you would like to receive your shots on campus, please call our office at 814-824-2431.

IV. FAMILY HEALTH HISTORY

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>IMMEDIATE FAMILY MEMBER</th>
<th>IF DECEASED</th>
<th>CAUSE</th>
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<tbody>
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<td>Alcoholism</td>
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<td>Cancer</td>
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<td>Thyroid Disease</td>
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</table>

Please list any other information you feel we should know about your health: ____________________________

Please PRINT CLEARLY Sections I through IV are completed by the student/parent.
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  |  814-824-2431 or via fax:  814-347-8275

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 __________________

Right Ear: Canal Normal ________ Canal Abnormal ________ T.M. Normal ________ Abnormal ________

Left Ear: Canal Normal ________ Canal Abnormal ________ T.M. Normal ________ Abnormal ________

Tonsils (Circle one): Present / Absent

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: ___________________________ Clear to percussion and auscultation

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

Heart Rate: ___________________________ Rhythm: ___________________________ 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: _____________________________________________________________

HEALTH CARE PROVIDER SIGNATURE

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/TESTING

Name of Applicant:

HEALTH CARE 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.) 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

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

4.) 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

5.) Were you born in one of the countries listed below that have a high incidence of active TB disease? □ Yes □ No

If yes, CIRCLE the countries below

6.) 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 below.


Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2017. Countries with incidence rates of ≥ 20 cases per 100,000 populations. For future updates, refer to www.who.int/tb/country/en/

- If the answer is YES to any of the above questions, Mercyhurst University requires TB testing prior to starting at the University (see page 5, #1).
- 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 (page 5, #2), 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.
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 (#2 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 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
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 jejunooileal 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 jejunooileal 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 SIGNATURE

Name: _____________________________
Signature: _____________________________
Address: _____________________________
Phone: _____________________________

Immunization and TB Screening Prepared by ACHA's Vaccine-Preventable Diseases Advisory Committee
American College Health Association
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.
   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
   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) _____ Quadrivalent Inactivated Influenza Vaccine (QIV) _____ 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 ____/____/________

HEALTH CARE PROVIDER SIGNATURE

MD, DO, NP or PA Signature: ____________________________  Phone #: ____________________________
PRINTED NAME: ________________________________________