Incoming Student Health Form
2015-2016 Academic Year

Student Health Services
900 University Avenue
Riverside, CA 92507
Campushealth.ucr.edu

Student Information - Enter the information in this section before printing this form.....

Personal Information

Student ID #: _____

Last Name _____ First Name _____ Initial _____ Date of Birth _____

Address _____ Age at Enrollment _____

City _____ State _____ Zip Code _____ Country _____

Student Status _____ Telephone _____ Emergency Telephone _____

☐ International Student Qtr/Yr Entering _____ Gender _____

☐ Undergraduate ☐ Graduate ☐ Professional

Tuberculosis Screening Questionnaire (to be completed by the student)

Have you ever had a positive TB skin test?	☐ Yes	☐ No
Have you ever had close contact with anyone who was sick with TB?	☐ Yes	☐ No
Have you ever been vaccinated with BCG (tuberculosis vaccine)?	☐ Yes	☐ No
Were you born in any of the countries listed below and arrived in the U.S. within the last 5 years? If yes, please CIRCLE the country below.	☐ Yes	☐ No
Have you traveled to/in any of the countries listed below? If yes, please CHECK the country or countries below.	☐ Yes	☐ No

Afghanistan	Cook Islands	Japan	Nicaragua	Sri Lanka
Algeria	Cote d'Ivoire	Kazakhstan	Niger	Sudan
Angola	Croatia	Kenya	Nigeria	Suriname
Argentina	Democratic People's Republic of Korea	Kiribati	Pakistan	Swaziland
Armenia	Democratic Republic of Congo	Kuwait	Palau	Syrian Arab Republic
Azerbaijan	Djibouti	Kyrgystan	Panama	Tajikistan
Bahrain	Dominican Republic	Lao People's Democratic Republic	Papua New Guinea	Thailand
Bangladesh	Ecuador	Latvia	Paraguay	Former Yugoslav Republic of Macedonia
Belarus	El Salvador	Lesotho	Peru	Timor-Leste
Belize	Equatorial Guinea	Liberia	Philippines	Togo
Benin	Eritrea	Libyan Arab Jamahiriya	Poland	Tongo
Bhutan	Estonia	Lithuania	Portugal	Trinidad and Tobago
Bolivia	Ethiopia	Madagascar	Qatar	Tunisia
Bosnia-Herzegovina	French Polynesia	Malawi	Republic of Korea	Turkey
Botswana	Gabon	Malaysia	Republic of Moldova	Turkmenistan
Brazil	Gambia	Maldives	Romania	Tuvalu
Brunei Darussalam	Georgia	Mali	Russian Federation	Uganda
Bulgaria	Ghana	Marshall Islands	Rwanda	Ukraine
Burkina Faso	Guam	Mauritania	Saint Vincent and the Grenadines	United Republic of Tanzania
Burundi	Guatemala	Mauritius	Sao Tome and Principe	Uruguay
Cambodia	Guinea	Micronesia (Federated States)	Senegal	Uzbekistan
Cameroon	Guinea-Bissau	Mongolia	Serbia	Vanuatu
Cape Verde	Guyana	Montenegro	Seychelles	Venezuela
Central African Republic	Haiti	Morocco	Sierra Leone	Vietnam
Chad	Honduras	Mozambique	Singapore	Yemen
China	India	Myanmar	Solomon Islands	Zambia
Columbia	Indonesia	Namibia	Somalia	Zimbabwe
Comoros	Iraq	Nepal	South Africa	
Congo				

IF THE ANSWER IS *YES* TO ANY OF THE ABOVE QUESTIONS, UC RIVERSIDE REQUIRES THAT A LICENSED HEALTHCARE PROVIDER COMPLETE THE TUBERCULOSIS RISK ASSESSMENT ON THE FOLLOWING PAGE. THE TUBERCULOSIS RISK ASSESSMENT MAY BE MAILED ALONG WITH PROOF OF IMMUNIZATIONS (THE SUPPLIED FORM OR A COPY OF YOUR OFFICIAL IMMUNIZATION RECORD).

IF YOU ANSWER NO TO ALL OF THE ABOVE QUESTIONS, PLEASE DISREGARD THE TUBERCULOSIS RISK ASSESSMENT AT THE BOTTOM OF THE FOLLOWING PAGE.

Student Information

Student ID #: _____

Last Name | First Name | Initial

STOP! - Read the instructions carefully.

Immunizations and Proof of Immunity

INCOMING STUDENTS SHOULD FILE PROOF OF IMMUNIZATIONS PRIOR TO THE START OF THEIR FIRST QUARTER OR SEMESTER. STUDENTS WHO HAVE NOT COMPLETED THIS FORM WILL HAVE A HOLD PLACED UPON THEIR REGISTRATION!

Have this form completed legibly in English by a licensed medical professional unrelated to the student.

OR

If the required immunizations have been documented on an official immunization record, a copy of the immunization record may be sent in lieu of a medical professional completing this form. Foreign records must be translated into English.

A. Measles-Mumps-Rubella (MMR) vaccine: Two (2) doses required for student born after 1957:

Month/Year

Dose #1 given at 12 months of age or later..... _____/_____

Month/Year

Dose #2 given at least 1 month after dose #1 and after 1981..... _____/_____

OR proof of positive immune titers (attach copy of lab report)... _____/_____

B. Hepatitis B vaccine

If the student is over 18 years of age (19 and up), skip to item C.

Hep B vaccine required if the student has not yet turned 19 on the first day of the entering quarter or semester.

☐ Hepatitis B vaccine 3-dose program initiated or completed.

Vaccine Dates (Month /Year): Dose #1 _____/_____ Dose #2 _____/_____ Dose #3 _____/_____

☐ Student has known immunity against the Hepatitis B virus by prior infection or by known immune antibody titer. (Copy of lab report required.)

Hepatitis B surface antibody titer _____ Date (Month/Year) _____/_____

☐ Student is a known chronic carrier of HBV therefore vaccine is not indicated.

C. Tetanus-Diphtheria-Pertussis (Tdap) vaccine booster

Month/Year

_____/_____

D. Meningococcal Vaccine (IS MANDATORY)

This vaccine is **MANDATORY** for enrollment at UC Riverside. One dose / booster dose after age 16 is recommended.

Date vaccine given (Month/Year) : _____/_____

FOR INTERNATIONAL STUDENTS ONLY

E. Polio vaccine primary series REQUIRED for International students.

Four (4) doses required in series. Date series completed..... _____/_____ **Month/Year**

Send this completed form to:

ATTN: Medical Records
Student Health Services
Riverside, CA 92507

Tuberculosis (TB) Risk Assessment

HAVE A LICENSED MEDICAL PROFESSIONAL COMPLETE THIS SECTION IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ON THE TUBERCULOSIS SCREENING QUESTIONNAIRE. IF YOU ANSWERED "NO" TO ALL OF THE QUESTIONS, YOU MAY SKIP THIS SECTION.

Tuberculosis (TB) Screening is REQUIRED for all students at higher than average risk for TB. Screening is MANDATORY for students who are foreign born, or who have traveled and arrived in the United States within the last 5 years from a high-prevalence area.

Examples of high-prevalence areas are Africa, Asia, Eastern Europe, Central or South America. For a more complete list, please refer to the country list on the Tuberculosis Screening Questionnaire (data from the World Health Organization list of countries with tuberculosis incidence greater than 20 cases per 100,000 population).

Tuberculosis Screening must be within 6 months prior to entry to UCI.

Tuberculin Skin Test (TST) : ☐ Negative ☐ Positive

Date Given (Month/Year) : _____/_____ Date Read (Month/Year) : _____/_____ Induration size _____mm (>10mm is positive)

OR

Interferon Gamma Release Assay (IGRA): (Specify method) QFT-G QFT-GIT T-SPOT Other _____

Date of Test (Month/Year) : _____/_____ Result: Negative Positive Indeterminate Borderline (T-Spot only)

Chest X-Ray (Required if TST or IGRA is POSITIVE)

Date of CXR (Month/Year) : _____/_____ Result _____

History of INH (Isoniazid) treatment? Yes No Date initiated (Month/Year) : _____/_____ Date Completed(Month/Year) : _____/_____

MEDICAL PROFESSIONAL CERTIFICATION REQUIRED

Name _____ Professional Title _____ License No. _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Signature indicates that all information on this page is true and accurate, to the best knowledge of the responsible medical professional.

_____ Signature

_____ Date