# Incoming Student Health Form

Student Health Services
900 University Avenue
Riverside, CA 92521
studenthealth.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 IMMUNIZATIONS & PROOF OF IMMUNITY FORM.

**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 REGISTRATION 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.

**A. Measles-Mumps-Rubella (MMR) vaccine:** Two (2) doses required

| | Month/Year | | Month/Year |
|---|---|---|---|
| Dose #1 given at 12 months of age or later..... | _____/_____ | Dose #2 given at least 1 month after dose #1 | _____/_____ |
| OR proof of positive immune titers (attach copy of lab report)... | _____/_____ | | |

**B. Tetanus-Diphtheria-Pertussis (Tdap) vaccine booster** — Month/Year _____/_____
One dose after age 7

**C. Meningococcal Conjugate-Serpgroups A, C, Y, W-135)** — Month/Year
One dose on or after age 16 for all students age 21 or younger.

**D. Varicella (chickenpox):** Two doses required — Month/Year

| | |
|---|---|
| Dose #1 given at 12 months of age or later | _____/_____ |
| Dose #2 given at least 1 month after dose #1 | _____/_____ |
| OR proof of positive immune titers (attach copy of lab report)... | _____/_____ |

Send this completed form to:
Student Health Services
ATTN: Immunization Requirement
900 University Ave.
Riverside, CA 92521
or fax to:
951-827-3133

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) Risk Assessment

**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 these pages is true and accurate, to the best knowledge of the responsible medical professional.

_____ Signature _____ Date **STAMP**