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 wellbeing 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) no later than **May 15, 2018**. 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.

A meningitis waiver **ONLY** if the student is requesting to waive the PA legal requirement for a meningitis vaccine. (form available at [http://my.mercyhurst.edu/orientation](http://my.mercyhurst.edu/orientation)). **Students without proof of a meningitis vaccine may not move into university housing unless a waiver is in place.**

**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. Pennsylvania law requires that all students must submit proof of one dose of meningococcal conjugate vaccine, or a signed waiver requesting exception, before being permitted to move into campus owned housing. Mercyhurst also requires two documented doses of the Measles-Mumps-Rubella (MMR) vaccine with the first being administered on or after the first birthday and the second dose at least one month later, OR by submitting a lab test (“titer”) documenting immunity. **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.**

**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.

**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 [my.mercyhurst.edu](http://my.mercyhurst.edu) (click on “Wellness and Resources”).

**International Students:** the meningitis vaccine administered outside the U.S. often does not protect against serogroups A, C, Y, and W135 (4 of the 5 most common U.S. strains). Students should consult their physician, and if a vaccine targeting these serogroups cannot be administered at home, the student must sign and return a meningitis waiver. Upon arrival to the U.S., students are strongly encouraged to obtain the vaccine.

**TB tests:** Any student 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.

Please return these completed forms to the Cohen Health Center either by faxing them to 814-824-2242 or mailing them to:

Mercyhurst University Cohen Student Health Center  
501 E. 38th Street  
Erie, PA 16546

If you have any questions, please contact the Cohen Health Center at [health@mercyhurst.edu](mailto: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
PLEASE PRINT CLEARLY Sections I through IV are completed by the student/parent.

I. Name in Full: ________________________________ Sex: ________________________________
   Home Address: ________________________________ City: ________________________________ State: ________________________________
   Home Phone: ________________________________ Student Cell Phone: ________________________________
   Age: ________________________________ Date of Birth: ________________________________ Marital Status: ________________________________
   Name of Parents/Spouse: ________________________________
   Insurance Company: ________________________________ Policy #: ________________________________
   Is referral from Primary Care physician needed? (Circle one) Yes / No
   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>
<tr>
<td>Alcoholism</td>
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<td>Thyroid Disease</td>
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   Please list any other information you feel we should know about your health: ________________________________
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 ___________________________

Ears:  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 (Check if true): ___________ Clear to percussion and auscultation

Thyroid (Circle one): Normal / Abnormal

Lymph Nodes (Circle one): Normal / Abnormal

Heart Rate: ___________________________ Rhythm: ___________________________ PMI: ___________________________ S1 & S2: ___________________________

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: _____________________________________________________________

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: ___________________________

Note to Provider: Please continue with Sections VI and VII.
VI. TUBERCULOSIS (TB) SCREENING/TESTING

Name of Applicant: ____________________________

HEALTHCARE 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.) 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)

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<td>China, Hong Kong SAR</td>
<td>Guam</td>
<td>Maldives</td>
<td>Papua New Guinea</td>
<td>Tajikistan</td>
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<td>Guatemala</td>
<td>Mali</td>
<td>Paraguay</td>
<td>Tanzania (United)</td>
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<td>Guinea</td>
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<td>Haiti</td>
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<td>Democratic People’s Republic</td>
<td>Honduras</td>
<td>Micronesia (Federated</td>
<td>Republic of Korea</td>
<td>Tunisia</td>
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<td>Belize</td>
<td>of Korea</td>
<td>India</td>
<td>States of)</td>
<td>Republic of Moldova</td>
<td>Turkmenistan</td>
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<td>Democratic Republic of the</td>
<td>Indonesia</td>
<td>Mongolia</td>
<td>Romania</td>
<td>Tuvalu</td>
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<td>Iraq</td>
<td>Montenegro</td>
<td>Russian Federation</td>
<td>Uganda</td>
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<td>Djibouti</td>
<td>Kazakhstan</td>
<td>Morocco</td>
<td>Rwanda</td>
<td>Ukraine</td>
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<tr>
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<td>Democratic Republic of</td>
<td>Kenya</td>
<td>Mozambique</td>
<td>Sao Tome and Principe</td>
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<td>Kyrgyzstan</td>
<td>Nauru</td>
<td>Sierra Leone</td>
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<td>Pakistan</td>
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3.) Have you had frequent or prolonged visits* to one or more of the countries listed above with a high prevalence of TB disease? (If yes, CHECK the countries above.)

4.) Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?

5.) Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease?

6.) 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?

If the answer is YES to any of the above questions, Mercyhurst University requires TB testing prior to starting at the University (see below).

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 (#1 below), 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 (#1 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 equiv-valent 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 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 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 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

HEALTH CARE PROVIDER

Name: ____________________________
Signature: _________________________
Address: __________________________
Phone: ____________________________
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  Birth in U.S. before 1980  Yes ___ No ___  
  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) _____  Live attenuated influenza vaccine (LAIV) _____
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 __/__/________

   MD, DO, NP or PA Signature: ________________________________  Phone #: ________________________________

PRINTED NAME: __________________________________________

Name of Applicant: ________________________________________