The pre-entrance health record/immunization form is due August 1st for full-time students enrolling in the Fall semester and January 4th for students enrolling in the Spring. Immunization records can be obtained by contacting your parents, family doctor, high school where you graduated (Google search for "Where can I get immunization records from name of high school and state"), previous university attended, military immunization record, or local Health Department. If you do not have an immunization record, see your Healthcare Provider to get the required vaccines. Bring your completed form to Preview. We require you to complete all vaccines (the Hepatitis B series should be started and may be completed during the school year). However, your immunization status will not be complete until all 3 doses have been received.

Virginia state law and Old Dominion University require all full-time students taking at least one credit on the Norfolk campus who enroll for the first time, to provide documentation of immunizations by a licensed health professional or health facility. **Students will not be allowed to register for second semester until requirements have been met.**

All full-time students entering Old Dominion University must submit a completed Health History Form and provide evidence of having received

- 2 doses of the Measles/Mumps/Rubella (MMR) vaccine after age 1.
- 1 dose of Meningitis vaccine after age 16 (or the signed waiver form) for students under age 22.
- 3 doses of Hepatitis B vaccine (or the signed waiver form).
- Tetanus/Diphtheria (Td) or Tetanus/Diphtheria/Pertussis (Tdap) vaccine booster within the last 10 years.

Full-time students are also required to complete the Tuberculosis (TB) Risk Assessment Questionnaire (Part B) on the Health History form. Students may be required to show proof of a recent PPD Tuberculosis Skin test or IGRA blood test based on risk factors for TB.

If this completed information is not received, a hold will block the student’s registration for second semester. **Click on the Patient Portal link to complete your personal medical history online, enter immunization dates, and upload your immunization documents.** If you prefer to submit the completed form by US mail, the form can be downloaded below. The mailing address is on the form.

Remember to keep a copy of your immunization forms for your records if you are mailing the form. Do not fax forms. They must be uploaded through the Patient Portal or mailed. Return or mail forms to:

Old Dominion University  
Student Health Services  
1007 South Webb Center  
Norfolk, VA 23529

Student Health Services  
1007 South Webb Center, Norfolk, VA 23529  
Phone: 757/683-3132 • www.odu.edu/studenthealth

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### PART A. To be completed by student

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>University Identification No.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Permanent Home Address</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year/Semester Entering ODU</td>
<td>Birthdate (mm/dd/yyyy)</td>
<td>Sex</td>
<td>M F</td>
<td>Ethnicity</td>
<td>Height (ft. in.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Person to notify in case of emergency</th>
<th>Relationship</th>
<th>Phone (H)</th>
<th>Phone (Cell)</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Status:</td>
<td>Full-time undergraduate</td>
<td>Part-time undergraduate</td>
<td>Full-time graduate</td>
</tr>
<tr>
<td>Have you previously submitted an immunization report?</td>
<td>YES</td>
<td>NO</td>
<td>E-mail:</td>
</tr>
<tr>
<td>Insurance: All students are recommended to have health insurance. International students must have health insurance.</td>
<td>Do you have health insurance?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Insurance Company</td>
<td>Policy Holder</td>
<td>I.D./Group Number</td>
<td></td>
</tr>
</tbody>
</table>

### Family History - Check if condition exists in your family (immediate family, grandparents, aunts, uncles, cousins)

- Cancer:
- Diabetes:
- Heart Disease:
- High Blood Pressure:
- Kidney Diseases/stones:
- Psychiatric Disorders:
- Family History of sudden death before age 50:

### Personal Medical History

- Allergies to Food, Drugs, Animals, Dust, Pollen, etc. List: _________________________________________________________________________________________________
- Medicines routinely taken (name, dosage, and frequency): _________________________________________________________________________________________________

### Do you have a history of any of the following medical conditions? Provide details of positive answers below.

<table>
<thead>
<tr>
<th>Allergies, Hay Fever</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
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<tr>
<td>Asthma</td>
<td></td>
<td></td>
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<tr>
<td>Bleeding Disorder</td>
<td></td>
<td></td>
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<tr>
<td>Cancer or malignancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Kidney Infection/stone</td>
</tr>
<tr>
<td>Disease/jury of bones/joints/muscles</td>
<td>Mononucleosis</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>Seizure disorder</td>
</tr>
<tr>
<td>Heart disease/nurur</td>
<td>Stomach/intestinal disorder</td>
</tr>
<tr>
<td>Hepatitis or Liver disease</td>
<td>Substance/alcohol abuse</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Thyroid disorder</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Menstrual problems</td>
<td>Breast problems</td>
</tr>
<tr>
<td></td>
<td>Testicular problems</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Any other illness:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hospitalizations:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Surgery:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Please describe any prior or current treatment by a mental health provider such as a psychiatrist, psychologist or counselor.</th>
</tr>
</thead>
</table>

### PERMISSION FOR TREATMENT

I understand that the information that I have given in the Pre-entrance Health Record is confidential and for the use of attending medical staff. I give permission to Old Dominion University to provide diagnostic, therapeutic, voluntary immunization, operative procedures and transportation as deemed necessary by the medical staff on my behalf. I understand that my health information will be used as necessary to coordinate and manage my health care, support the operations of Student Health Services and to comply with state/federal laws.

### DEEMED CONSENT FOR HIV TESTING (VIRGINIA STATE LAW) 32.1-45.1

Testing required if direct exposure to body fluids outlined in CDC guidelines.

### AUTHORIZATION OF PAYMENT

I hereby authorize Old Dominion University to bill me for services provided. I will be responsible for any legal and/or collection fees resulting from non-payment. Permission is given to Old Dominion University, Student Health Services to release information upon request regarding claim for the notified charges, to my insurance company, to facilitate payment of insurance claims.

I have been informed of and understand the above statements regarding permission for treatment, deemed consent and authorization of payment.

### FOR STUDENTS UNDER 18 YEARS: CONSENT FOR TREATMENT OF MINORS

This consent form must be signed by the natural parent or legal guardian of minors (under 18 years) so that appropriate diagnosis and treatment may be promptly carried out, and so that no unnecessary delays will occur with health service procedures. Under certain circumstances the student will be transported to local hospitals for diagnosis and treatment. I have been informed of and understand the above statements regarding permission for treatment, deemed consent and authorization of payment.

I give permission for such diagnostic, therapeutic, voluntary immunization, operative procedures and transportation as deemed necessary for my son/daughter who is under the age of eighteen (18) years. No treatments will be given if not signed.

Parent/Guardian Name: ____________________________

Parent/Guardian Signature: ________________________

Date: __/__/____

(No treatment will be given if not signed) Date: __/__/____
Part B. Tuberculosis Risk Assessment Must Be Completed By Student

Name: ____________________________ UNI: ____________________________

Country of Birth: ____________________________ U.S. Arrival Date (if born outside U.S.): ____________________________

In the last 5 years, have you lived or traveled outside the U.S.? ☐ Yes ☐ No

If yes, list Country and full travel dates: _______________________________________________________________

***See Attachment for list of countries or territories which have a high incidence of active TB disease.

The United States Public Health Service and the Centers for Disease Control and Prevention recommend that tuberculosis screening be performed in all individuals who may be at increased risk of tuberculosis.

Place a check in the yes or no boxes below. A TB skin test (PPD) or IGRA (TB blood test) is required if yes is checked in any section below or high risk travel.

☐ Yes ☐ No Section 1: Check if you have any of the following symptoms:
- Persistent cough of unknown etiology for more than 3 weeks/coughing bloody sputum
- Unexplained fever for more than 1 week
- Unexplained weight loss
- Night sweats/Chills/Fatigue/Loss of appetite

☐ Yes ☐ No Section 2: Check if any of these situations apply to you:
- Close contact with a known or suspected case of active tuberculosis
- Use of illegal injected drugs
- At risk of being infected with HIV (Human Immunodeficiency Virus)
- Volunteer, resident, or employee in a healthcare facility or congregate living setting (homeless shelter, nursing home, correctional facility)

☐ Yes ☐ No Section 3: Check if you have any of the following health condition risk for tuberculosis:
- Previous positive TB skin test or blood test
- HIV infection
- Cancers, Leukemia, Lymphoma
- Prolonged corticosteroid therapy or other immunosuppressive therapy (i.e., Mycophenolate, Embrel, or Remicade); chemotherapy
- Diabetes
- Chronic renal failure/Organ transplant (kidney, heart)
- Chronic Lung Disease (does not include Asthma)
- Chronic malabsorptive conditions

To be completed by health care provider if TB risk factors listed in 1 or more sections above

TB skin test (PPD) or IGRA blood test is required. Prior BCG vaccine does not exempt student from TB testing.

1. Tuberculin Skin Test (PPD) must be placed on or after May 1 for fall semester or September 1 for Spring semester.
   Date applied: ___________ Date read: ___________ Result (millimeters of induration): ________ Interpretation: ☐ Positive ☐ Negative

2. Interferon Gamma Release Assay (IGRA) (TB blood test) drawn on or after May 1 for fall semester or September 1 for spring semester.
   Attach report
   Date obtained: ___________ Specimen method: ☐ QFT-G ☐ QFT-GT ☐ QFT-IT Spot Result: ☐ Negative ☐ Positive ☐ Indeterminate ☐ Borderline

3. Chest X-Ray (required on or after May 1 for fall semester or September 1 for spring semester if Tuberculosis Skin test or IGRA listed above is positive)
   Date of chest x-ray: ___________ Result: ☐ Normal ☐ Abnormal INH Initiated: ☐ Yes ☐ No if yes, Date Initiated: ___________

4. History of past positive PPD or IGRA (please circle):
   Date of positive PPD/IGRA: ___________ Date INH completed: ___________ Date x-ray completed: ___________ Date x-ray not completed, a chest x-ray is required on or after May 1 for Fall semester or after May 1 for Fall semester or September 1 for Spring semester)
   Date of x-ray: ___________

Healthcare Provider signature: ____________________________ Date: ___________ Healthcare Provider Address and clinic stamp ____________________________

SUBMIT THIS FORM WITH YOUR IMMUNIZATION DOCUMENTATION

Student Health Services
1007 South Webb Center, Norfolk, VA 23529
Phone: 757/683-3132 • www.odu.edu/studenthealth

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Countries and territories with high prevalence of TB disease.

Afghanistan  Comoros  Iraq  Namibia  Solomon Islands
Algeria  Congo  Kazakhstan  Nauru  Somalia
Angola  Côte d’Ivoire  Kenya  Nepal  South Africa
Anguilla  Democratic People’s Republic of Korea  Kiribati  New  South Sudan
Argentina  Democratic Republic of the Congo  Kuwait  Caldonia  Sri Lanka
Armenia  Djibouti  Kyrgyzstan  Nicaragua  Sudan
Azerbaijan  Dominican Republic  Laos People’s Democratic Republic  Niger  Swaziland
Bangladesh  Ecuador  Latvia  Nigeria  Syrian Arab Republic
Belarus  El Salvador  Lesotho  Northern Mariana Islands  Tajikistan
Belize  Equatorial Guinea  Liberia  Palau  Thailand
Benin  Eritrea  Libya  Panama  Timor-Leste
Bhutan  Ethiopia  Lithuania  Papua New Guinea  Togo
Bolivia (Plurinational State of)  Fiji  Madagascar  Paraguay  Tunisia
Bosnia and Herzegovina  Gabon  Malawi  Peru  Turkmenistan
Botswana  Georgia  Malaysia  Philippines  Tuvalu
Brazil  Ghana  Maldives  Qatar  Uganda
Brunei Darussalam  Greenland  Mali  United Republic of Tanzania
Bulgaria  Guam  Marshall Islands  Uruguay  Ukraine
Burkina Faso  Guatemala  Mauritania  Uzbekistan
Burundi  Guinea  Mauritius  Vanuatu
Cabo Verde  Guinea-Bissau  Mexico  Venezuela (Bolivarian Republic of)
Cameroon  Guyana  Micronesia (Federated States of)
Cambodia  Haiti  Mongolia  Viet Nam
Cameroon  Honduras  Montenegro  Zambia
Central African Republic  India  Morocco  Zimbabwe
 Chad  Indonesia  Mozambique  China, Hong Kong SAR
China  India  Myanmar  China, Macao SAR
Colombia  Indonesia  Nagorno Karabakh

Please take this immunization documentation form to your Healthcare Provider for completion. Then upload the completed document to Student Health Services by using the Patient Portal document upload.

Student's Name ____________________________ ____________________________ ____________
Last, First Middle Initial

UIN ____________________________

Required Immunizations

1. Meningococcal Vaccine (Required A,C,W,Y) Given on or after the 16th birthday ____________
   Vaccine used: □ Menactra □ Menumune □ Menevo
   or signed Waiver (see below). Vaccine information on SHS website. Optional: Meningococcal B ____________
   Vaccine used: □ Bexsero □ Trumenba
   WAIVER: I have been fully informed of the risks and health hazards of meningococcal infection as well as the benefits of the Meningococcal vaccine. I choose not to be immunized against meningococcal infection.

   Student signature (parent/legal representative if under age 18): ____________________________

2. M.M.R. (Measles, Mumps, Rubella) Age exempt for measles/mumps/rubella? Yes □ No □
   (after 1st birthday and after May 1971)
   (Born before 1957)
   Dose 1: ____________ Dose 2: ____________
   Month Day Year Month Day Year
   OR INDIVIDUAL VACCINES

   Measles Mumps Rubella
   (2 doses not prior to 1968) (2 doses not prior to June 1969) (1 dose not prior to June 1969)
   Dose 1: ____________ Dose 1: ____________ Dose 1: ____________
   Month Day Year Month Day Year Month Day Year
   or **Upload laboratory proof of immunity to all 3 diseases (equivocal or negative titers not acceptable)

3. Tetanus-Diphtheria
   Within last 10 years)
   OR
   Tdap
   (Within last 10 years)
   Dose 1: ____________ Dose 2: ____________
   Month Day Year Month Day Year
   4. Polio (Series Completed)
   Dose 1: ____________ Dose 2: ____________
   Month Day Year Month Day Year

5. Hepatitis B: Completed series? Yes □ No □ Dates: 1) ____________ 2) ____________ 3) ____________
   or 2 dose adolescent series [Manufacturer: Merck-ages 11 through 15 ONLY]: Dates: 1) ____________ 2) ____________
   or **Upload laboratory proof of immunity
   WAIVER: I have been fully informed of the risks and health hazards of hepatitis B infection as well as the benefits of the hepatitis B vaccine. I choose not to be immunized against hepatitis B infection.

   Student signature (parent/legal representative if under age 18): ____________________________

HEALTH CARE PROVIDER
I have reviewed the immunization records of this patient and certify that the entries above are correct.

Signature of Health Professional ____________________________
Date ____________________________
Telephone ____________________________
Office Address and Clinic Stamp

Student Health Services
1007 South Webb Center, Norfolk, VA 23529
Phone: 757/683-3132 • www.odu.edu/studenthealth

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