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

Last Name | First Name | Middle Initial | University Identification No.
---|---|---|---

Permanent Home Address Street | City | State | Zip | Phone
---|---|---|---|---

Year/Semester Entering ODU | Birthdate (mm/dd/yyyy) | Sex: M F | Ethnicity | Height (ft. in.) | Weight: (lbs.)
---|---|---|---|---|---

Person to notify in case of emergency | Relationship | Phone (H) | Phone (Cell)
---|---|---|---

School Status: ☐ Full-time undergraduate | ☐ Part-time undergraduate | ☐ Full-time graduate | ☐ Part-time graduate

Have you previously submitted an immunization report? ☐ YES ☐ NO E-mail:

Insurance: All students are recommended to have health insurance. International students must have health insurance. Do you have health insurance? ☐ YES ☐ NO

Insurance Company | Policy Holder | ID/Group Number
---|---|---

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

- Cancer
- Diabetes
- Heart Disease
- High Blood Pressure
- Kidney Disease/stones
- Asthma/Lung Disease
- Psychiatric Disorders
- Suicide
- Tuberculosis
- Family History of sudden death before age 50

Yes ☐ No ☐

Personal Medical History

Allergies to Food, Drugs, Animals, Dust, Pollen, etc. List:

Meditcines 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>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies, Hay Fever</td>
<td>☐</td>
<td>☐</td>
</tr>
<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>
</tr>
<tr>
<td>Cancer or malignancy</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Depression</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Diabetes</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Kidney infection/stone</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Kidney Disease/stones</td>
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<td>Kidney infection/stone</td>
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<tr>
<td>Komenocides</td>
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<tr>
<td>Disease/injury of</td>
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<td>☐</td>
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<tr>
<td>bones/joints/muscles</td>
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<tr>
<td>Disease/injury of</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>bones/joints/muscles</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Seizure disorder</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Stomach/intestinal</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Disorder/diabetes</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Disorders/diabetes</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Substance/alcohol abuse</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Thyroid disorder</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Menstrual problems</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Breast problems</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Testicular problems</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Any other illness:

Hospitalizations:

Surgery:

Please describe any prior or current treatment by a mental health provider such as a psychiatrist, psychologist or counselor:

________________________

________________________

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.

AUTHORIZED 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 noted 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. Student’s Signature: __________________________

(NOT treatment will be given if not signed) Date __/__/____

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 treatment will be given if not signed.

Parent/Guardian Name: __________________________ Parent/Guardian Signature: __________________________ Date __/__/____
Part B. Tuberculosis Risk Assessment Must Be Completed By Student

Name: ___________________________ UIN: ________________________
Country of Birth: ___________________________ U.S. Arrival Date (if born outside U.S.): ____________

Have you lived or traveled outside the U.S. for 3 months or more? [ ] Yes [ ] No
If yes, list country and length of travel to each country:

***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:
- Prolonged corticosteroid therapy or other immunosuppressive therapy (i.e. Hymira, 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: _____________ Specify method: [ ] QFT-G [ ] QFT-IT [ ] QFT-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 Attach report 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: _____________ If INH 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 _____________ Attach Report

   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

Old Dominion University is an equal opportunity, affirmative action institution.
Countries and territories with high prevalence of TB disease.

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

OLD DOMINION UNIVERSITY
IDEA FUSION

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 ___________________________ UIN ___________________________

Last, First Middle Initial

Required Immunizations

1. Meningococcal Vaccine (Required A,C,W,Y) Given on or after the 16th birthday ___________ ___________ Vaccine used: □ Menactra □ Menomune □ Menveo
(Required for students < 22 years of age) Month Day Year
or signed Waiver (see below). Vaccine Information on SHS website. Optional: Meningococcal B ___________ ___________ Vaccine used: □ Bexsero □ Trumenba
Month Day Year

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 or **Upload laboratory proof of immunity to all 3 diseases (equivocal or negative titers not acceptable)

Measles
(2 doses not prior to 1968)
Dose 1: ___________ ___________ Dose 2: ___________ ___________
Month Day Year Month Day Year

Mumps
(2 doses not prior to June 1969)
Dose 1: ___________ ___________ Dose 1: ___________ ___________
Month Day Year Month Day Year

Rubella
(1 dose not prior to June 1969)
Dose 1: ___________ ___________ Dose 1: ___________ ___________
Month Day Year Month Day Year

3. Tetanus-Diphtheria
Within last 10 years

OR
Tdap
(Within last 10 years)

4. Polio (Series Completed)

**Tetanus/Diphtheria/Pertussis titers are not acceptable as proof of current vaccination status per Centers for Disease Control (CDC)

Month Day Year

5. Hepatitis B: Completed series? Yes □ No □ Dates: 1) ___________ ___________ 2) ___________ ___________ 3) ___________ ___________
Month Day Year Month Day Year Month Day Year
or 2 dose adolescent series [Manufacturer: Merck-ages 11 through 15 ONLY]: Dates: 1) ___________ ___________ 2) ___________ ___________
Month Day Year Month Day Year

or signed Hepatitis B Waiver (see below) Vaccine information available on SHS website.

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 ___________________________

Printed Name of Health Professional ___________________________ Telephone ___________________________

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

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