WHITWORTH

2012-
2013

HEALTH HISTORY AND IMMUNIZATION FORM

This form must be submitted by June 15.

As a new student at Whitworth University, part of your admission paperwork is to complete the Whitworth University Health and Counseling Center Health History and Immunization Form. Please complete the following information in its entirety. Instructions for submission of this form are detailed at the end of the document. All information in this form remains CONFIDENTIAL. (Student athletes have an additional form to complete for the athletics department by Aug. 1. The form can be found online.)

Name: ________________________________
Last First MI

Date:___/____/____

DEMOGRAPHIC and INSURANCE INFORMATION

Please fill in the following information as completely as possible.

Student I.D. #: ______	**Date entering Whitworth:** / / Mo /Day/Year **Year in School:** ☐ Fr ☐ So ☐ Jr ☐ Sr ☐ Graduate **Program of study:**_	**Date of Birth:** / / _ **Age:**	☐ **Male** ☐ **Female**
Local Address or Dorm:			
Cell (or local) Phone: (_____) ______ - ______			

Father's name:	First Last	**Mother's name:**	First Last
Address:	Street City State Zip	**Address:**	Street City State Zip
E-mail:		**E-mail:**	
Home phone:	(_____) ______ - ______	**Home phone:**	(_____) ______- ______
Business phone:	(_____) ______ - ______	**Business phone:**	(_____) ______ - ______
Cell phone	(_____) ______ - ______	**Cell phone**	(_____) ______ - ______
Is this parent an emergency contact?	☐ Yes ☐ No	**Is this parent an emergency contact?**	☐ Yes ☐ No

Are you covered by insurance through . . .
(Check all that apply): ☐ Father? ☐ Mother? ☐ Self? ☐ Whitworth? ☐ Other?______

Head of household:	First Last	**Other parent/spouse:**	First Last
Date of birth:	/ / Mo / Day/Year	**Date of birth:**	/ / Mo / Day/Year
Employer name:		**Employer name:**	
Employer phone:	( ) -	**Employer phone:**	( ) -
Insurance co. name:		**Insurance co. name:**	
Insurance co. phone:	( ) -	**Insurance co. phone:**	( ) -
Insurance I.D. #:		**Insurance I.D. #:**	
Is student insured?	☐ Yes ☐ No	**Is student insured?**	☐ Yes ☐ No

If there is a change in coverage or if coverage expires, I agree to notify the Whitworth University Health Center of this development and update the insurance information I have on file. ☐ Yes

Name: ________________________________
Last First MI

Date:___/____/____

Emergency contact (other than parent):	________ First Last	Relationship:	________
Address:	Street ________ City State Zip		
Home phone:	( ) -	Business - phone:	( ) -
Cell phone	( ) -	E-mail:	________

Marital Information (if applicable):	Spouse's name:	________ First Last			
Address:	Street ________ City State Zip		Email: ________		
Home phone:	( ) -	Business phone:	( ) -	Cell phone:	( ) -

PAST MEDICAL HISTORY

Please fill out the following medical information as completely as possible. This information will remain strictly confidential and is for use by the Whitworth University Health Center use only.

ALLERGIES:

Please complete the following.

☐ NO KNOWN ALLERGIES

Allergy to:	Type of reaction?
☐ Aspirin	
☐ Codeine	
☐ Penicillin	
☐ Sulfa	
☐ Latex	
☐ Environmental (list): ________	
☐ Food (list): ________	
☐ Medications (please list other than above): ________	
☐ Other ________	

Name: ________________________________ Date:___/____/____
Last First MI

MEDICATIONS (*please list*):
(including non-prescription, supplements, herbs, birth-control pills, laxatives, inhalers, diet pills, etc.)

MEDICAL HISTORY:
Have you ever had or do you now have any of the conditions below?

☐ **Abdominal pain (chronic)**	☐ **Eating disorder**	☐ **Malaria/tropical diseases**
☐ **Acne**	☐ **Eczema/psoriasis**	☐ **Mononucleosis**
☐ **Allergies/hay fever**	☐ **Emotional/physical/sexual abuse**	☐ **Ovarian cyst**
☐ **Anemia**	☐ **Endometriosis**	☐ **Pneumonia**
☐ **Anorexia**	☐ **Epilepsy/seizures**	☐ **Rheumatic fever**
☐ **Arthritis**	☐ **Exercise-induced asthma**	☐ **Self- injury/cutting**
☐ **Asthma**	☐ **Eye/ear/nose/throat problems**	☐ **Sinusitis**
☐ **Back problems/injury**	☐ **Gallbladder problems**	☐ **Sleeping difficulty**
☐ **Bladder/kidney problems**	☐ **Headaches/migraines**	☐ **Suicide attempt(s)**
☐ **Blood-clotting disorder**	☐ **Hearing problems**	☐ **Suicidal thoughts**
☐ **Breast lump**	☐ **Heart murmur**	☐ **Thyroid problem**
☐ **Bulimia**	☐ **Heart problems**	☐ **Tuberculosis**
☐ **Cancer/tumor**	☐ **Hepatitis**	☐ **Ulcers (stomach/duodenal)**
☐ **Chest pain**	☐ **Hernia**	☐ **Vision problems**
☐ **Chicken pox**	☐ **High blood pressure**	☐ **Weight loss/gain > 10 lbs. (*recent*)**
☐ **Concussion/head injury**	☐ **High cholesterol**	☐ **Other health problems (please list):**
☐ **Congenital heart disease**	☐ **HIV/Aids**	
☐ **Depression/anxiety**	☐ **Hives**	
☐ **Diabetes**	☐ **Intestinal/bowel problems**	
☐ **Dizziness/fainting/vertigo**	☐ **Liver disease**	

REPRODUCTIVE HISTORY:
Please complete the following.

Males (please complete):
Undescended testicle: ☐ No ☐ Yes
Testicular mass, lump: ☐ No ☐ Yes
Sexually transmitted infections / Sexually transmitted disease (STIs/STDs): ☐ No ☐ Yes
Type of STI: ☐ Herpes ☐ Chlamydia ☐ Gonorrhea ☐ Syphilis ☐ HPV/Condyloma/Warts ☐ Other:

Females (please complete):	
Menstrual flow: ☐ Regular ☐ Irregular ☐ Absence of	Abnormal pap smear: ☐ No ☐ Yes
Duration of period: days	Sexually transmitted infections / Sexually transmitted disease (STIs/STDs): ☐ No ☐ Yes
Length of cycle: days	Type of STD/STI: ☐ Herpes ☐ Chlamydia ☐ Gonorrhea ☐ Syphilis ☐ HPV/Condyloma/Warts ☐ Other:
Pain/cramps with period: ☐ No ☐ Yes	Number of: Pregnancies Abortions Miscarriages Live births
Date of last pap smear: ☐ None / month/year	

Name: ________________________________ Date:___/____/____
Last First MI

SURGERIES / ACCIDENTS / HOSPITALIZATIONS:
Please complete the following.

Date:_	**Type:_**
Date:_	**Type:_**
Date:_	**Type:_**
Date:_	**Type:_**
Other:_	

FAMILY HISTORY

Have any of your blood relatives had any of the conditions below?

☐ Alcohol/substance abuse	☐ Diabetes	☐ Sickle Cell Trait/Disease
☐ Arthritis	☐ Epilepsy/seizure disorder	☐ Type?
☐ Asthma	☐ Hearing problems	☐ Vision problems
☐ Blood disorder	☐ Kidney disease	
☐ Cancer	☐ Learning disabilities	
☐ Cardiovascular Disease	☐ Marfan Syndrome	
☐ Heart attack before age 55	☐ Migraine	
☐ High blood pressure	☐ Mental-health problems	
☐ High cholesterol	☐ Depression	
☐ Stroke	☐ Anxiety	
☐ Other *(Please list.)*	☐ Other	
Adopted: ☐ **Yes**		
If adopted, family health history information known? ☐ **No** ☐ **Yes**		

SOCIAL HISTORY

Please complete the following.

Tobacco:	Cigarettes use: ☐ Never ☐ Quit date / month/year ☐ Current packs/day for years
	Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew
	Interested in quitting: ☐ No ☐ Yes
Alcohol:	Alcohol use: ☐ No ☐ Yes Number of drinks per week / week
	Is your alcohol use a concern for you or others? ☐ No ☐ Yes
Drugs (marijuana	Drug use:

or recreational drugs):	☐No ☐Yes Type(s) Number of times per week /week
	Have you ever used needles to inject drugs? ☐No ☐Yes
Sexual health:	Sexually active: ☐No ☐Yes Sexual partner(s) ☐male ☐female ☐both Number of partners
	Birth-control methods ☐No ☐Yes Type(s)_
	Safe-sex practices ☐No ☐Yes Type(s)_
Exercise:	Do you exercise regularly? ☐No ☐Yes
	Type of exercise: Number of times per week /week Duration minutes
Food:	How many meals per day do you eat? /day
	What food groups do you eat regularly? ☐breads ☐fruit ☐ vegetables ☐ meat/fish ☐dairy
Caffeine:	Do you consume caffeinated beverages regularly? ☐No ☐Yes Cups/cans per day? /day
Body piercings / Tattoos:	☐No ☐Yes
Safety:	☐No ☐Yes Do you use seatbelts consistently? ☐No ☐Yes Do you use a bike helmet regularly? ☐No ☐Yes Is violence at home a concern for you? ☐No ☐Yes ☐N/A Do you feel safe in your current relationship? *Guns are prohibited on Whitworth University campus.*

Name: ___________________________________
Last First MI

Date:___/____/____

IMMUNIZATION RECORD

PART I

Please complete the following information. The Whitworth Health Center strongly recommends that students receive the following immunizations prior to arrival on campus, in accordance with the Centers for Disease Control. These immunizations help ensure a healthier student body and protect the individual and others from illnesses that can be serious and even life-threatening. If you choose for medical, religious, or personal reasons not to receive immunizations, you must have your healthcare provider complete the *Certificate of Exemptions Form* (APPENDIX B) at the end of this document (also on the Whitworth University website). The following link contains recommendations from the American College Health Association regarding immunizations for college-aged students.

http://www.acha.org/Publications/docs/Recommendations%20for%20Institutional%20Prematriculation%20Immunizations_Jan2009.pdf

MEASLES, MUMPS, RUBELLA (MMR)	**Two doses required at least 28 days apart for students born after 1956.**
	Dose # 1 / / given at age 12 months or later. Mo./Day/Year
	Dose # 2 / / given at least 28 days after first dose. Mo./Day/Year
TETANUS, DIPHTHERIA, PERTUSSIS (TD, DTP, DTaP, or TDaP)	**Tdap booster recommended for ages 11-64 unless contraindicated.**
	Primary series completed? Yes ☐ No ☐ Date of last dose in series: Date: / / Mo./Day/Year
	Date of most recent booster: Date: / / Mo./Day/Year Type of booster: Td ☐ Tdap ☐
***MENINGOCOCCAL QUADRIVALENT (MENINGITIS)**	**One or 2 doses for college students – revaccinate every 5 years if increased risk continues.**
	Quadrivalent conjugate (preferred; administer simultaneously with Tdap, if possible). Dose # 1 / / Mo./Day/Year Dose # 2 / / Mo./Day/Year
	--OR-- Quadrivalent polysaccharide (acceptable alternative if conjugate not available). Date / / Mo./Day/Year

Name: ________________________________
Last First MI

Date:___/____/____

<table>
<tr><td>POLIO</td><td>Primary series, doses at least 28 days apart. Three different primary series are acceptable.

OPV alone (oral Sabin; three doses):
1 / / Mo./Day/Year #2 / / Mo./Day/Year #3 / / Mo./Day/Year

--OR--
IPV/OPV sequential:
IPV # 1 / / Mo./Day/Year IPV # 2 / / Mo./Day/Year
OPV # 3 / / Mo./Day/Year OPV # 4 / / Mo./Day/Year

--OR--
IPV alone (injected Salk; four doses):
1 / / Mo./Day/Year # 2 / / Mo./Day/Year # 3 / / Mo./Day/Year # 4 / / Mo./Day/Year</td></tr>
<tr><td>VARICELLA (CHICKEN POX)</td><td>Birth in the U.S. before 1980, a history of chicken pox, a positive Varicella antibody, or two doses of vaccine meets the requirement.

Birth in U.S. before 1980?
Yes ☐ No ☐

--OR--
History of this disease?
Yes ☐ No ☐

--OR--
Varicella antibody: / / Mo./Day/Year Result: ☐ Reactive ☐ Non-reactive

--OR--
Immunization:
Dose # 1 / / Mo./Day/Year
Dose # 2 / / Mo./Day/Year

Dose no. 2 given at least 12 weeks after first dose at ages 1-12 years and at least four weeks after first dose for those 13 years or older.</td></tr>
<tr><td>HUMAN PAPILLOMAVIRUS VACCINE (HPV2 or HPV4)</td><td>Three doses of vaccine for female or male college students 11-26 years of age at 0, 1/2, and six-month intervals.

Dose #1 / / Mo./Day/Year ☐ Gardasil ☐ Cervarix
Dose #2 / / Mo./Day/Year ☐ Gardasil ☐ Cervarix
Dose #3 / / Mo./Day/Year ☐ Gardasil ☐ Cervarix</td></tr>
<tr><td></td><td></td></tr>
</table>

Name: ________________________________ Date:___/____/____
Last First MI

HEPATITIS A	Immunization (Hepatitis A): Dose # 1 / / Mo./Day/Year Dose #2 / / Mo./Day/Year **--OR--** Immunization (*combined Hepatitis A and B vaccine*): Dose # 1 / / Mo./Day/Year Dose # 2 / / Mo./Day/Year Dose # 3 / / Mo./Day/Year
HEPATITIS B	Immunization (Hepatitis B): Dose # 1 / / Mo./Day/Year Dose # 2 / / Mo./Day/Year Dose # 3 / / Mo./Day/Year **--OR--** Immunization (combined Hepatitis A and B vaccine): ☐ Already completed under section *Hepatitis A* above **–OR--** Dose # 1 / / Mo./Day/Year Dose # 2 / / Mo./Day/Year Dose # 3 / / Mo./Day/Year **--OR--** Hepatitis B surface antibody: Date: / / Result: Reactive ☐ Non-reactive ☐ Mo./Day/Year
INFLUENZA (FLU)	Date of last dose: Date: / / Mo./Day/Year

Name: ________________________________ Date:___/____/____
Last First MI

PNEUMOCOCCAL POLYSACCHARIDE VACCINE (PNEUMONIA)	**One dose for members of high-risk groups (chronic medical issues) only.** Date: / / Mo./Day/Year

*The state of Washington mandates that all incoming college students receive educational information on meningococcal disease (meningitis). This illness is largely preventable with adequate vaccination. College-aged students residing in a campus setting are at greater risk than other young adults who do not reside in a campus setting. Students are at risk of developing the disease if they are not protected through immunization. Further information is available at the end of this document (Appendix D) and through the links listed below and on our website, through the following links.

http://www.vaccineinformation.org/menin/
http://www.immunize.org/catg.d/p4210.pdf
http://www.cdc.gov/vaccines/vpd-vac/mening/who-vaccinate.htm
http://www.cdc.gov/meningitis/index.html
http://www.nmaus.org/pdf/brochures/NMA%20Brochure_150%20DPI.pdf
http://here.doh.wa.gov/materials/meningococcal-disease/15_Meningoc_E08L.pdf

Name: ________________________________ Date:___/____/____
Last First MI

IMMUNIZATION RECORD

PART II

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2009. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://apps.who.int/ghodata/?vid=510.

TUBERCULOSIS (TB) SCREENING/TESTING:

Please answer the following questions.

Have you ever had a positive TB skin test? ☐No ☐Yes

Have you ever had close contact with anyone who was sick with TB? ☐No ☐Yes

Were you born in one of the countries listed below and did you arrive in the U.S. within the past five years? ☐No ☐Yes
(If yes, please mark an "X" in the box by the country on the next page.)

*Have you ever traveled to/in one or more of the countries listed below? (Please indicate which countries below.) ☐No ☐Yes

Have you ever been vaccinated with BCG? ☐No ☐Yes

Have you ever injected illicit drugs or used other high-risk substances (e.g. crack cocaine)? ☐No ☐Yes

Have you ever been diagnosed with HIV or AIDS? ☐No ☐Yes

**The significance of the travel exposure should be discussed and evaluated with a healthcare provider.*

If the answer is NO to all of the above questions, no further testing or action is required. If the answer is **YES** to **any** of the above questions, the Whitworth University Health Center requires that your **healthcare provider** complete a tuberculosis risk assessment prior to the start of classes. Please see the *TB Risk Assessment* form below (APPENDIX C) or on our website. Submit the *TB Risk Assessment Form* with this *Health History and Immunization Form* after it is completed by your healthcare provider.

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

Name: ________________________________ Date:___________
Last First MI

COMPLETION OF HEALTH HISTORY AND IMMUNIZATION FORM

In order to submit your completed *Health History and Immunization Form*, please review the following:

- ☐ Have you completed the form in its entirety?
- ☐ Have you completely filled in the immunization portion of the form?
- ☐ Have you had your parent/guardian complete, sign, and date the *Medical and Surgical Authorization* form? (Link found in Appendix A — ONLY for those who under 18 years of age.)
- ☐ Have you had your healthcare provider complete, sign, and date the *Certificate of Exemption Form*? (Link found in Appendix B — ONLY for those who claim exemption to immunizations.)
- ☐ Have you had your healthcare provider complete, sign, and date the *Tuberculosis (TB) Risk Assessment* form? (Link found in Appendix C — ONLY for those who answered "yes" to any of the questions in the Tuberculosis Screening/Testing section.)
- ☐ Have you read the meningococcal disease and human papillomavirus information found at the end of this document? (Appendix D — mandated education by the State of Washington for all incoming college and university students.)

If you have checked off all of the above information, please submit the *Health History and Immunization Form*, along with any additional forms (*Medical and Surgical Authorization, Certificate of Exemption, and Tuberculosis (TB) Risk Assessment*) by fax or mail:

Address:
Whitworth University Health and Counseling Center
300 West Hawthorne Road
Spokane, WA 99251

Fax:
877.844.1709

Name: ______________________________ Date:__________
Last First MI

MEDICAL AND SURGICAL AUTHORIZATION — APPENDIX A

(If you are under the age of 18, your parent/guardian must complete and sign this portion of the form.)

I hereby authorize and give my consent to the healthcare providers of Whitworth University or their designated licensed provider to perform upon or administer to

NAME OF STUDENT:

any reasonably necessary medical or surgical treatment. I also give permission to administer whatever anesthetic may be necessary or advisable during medical or surgical procedures. This authorization is intended to cover emergency treatment, immunizations, injections, and minor operations and procedures.

In the event of indicated major surgery or major operation, university authorities or healthcare providers are not hereby excused from attempting to contact me by phone, or mail, before relying upon this authorization. This authorization does not entitle the healthcare providers to render any medical or surgical treatment without the student's personal consent, unless the student is unable to give consent.

This permission is good only while the student is attending Whitworth University and only until the student's 18th birthday.

PARENT/GUARDIAN NAME:

RELATION TO STUDENT:

X
SIGNATURE:

/ /
DATE:

TELEPHONE NUMBER:

ADDRESS:

Please submit the *Medical and Surgical Authorization Form* in addition to your *Health History and Immunization Form*.

Fax or mail to:
Whitworth University Health and Counseling Center
300 West Hawthorne Road
Spokane, WA 99251
Fax: 877.844.1709

Name: ________________________________ Date:___________
Last First MI

CERTIFICATE OF EXEMPTION—APPENDIX B

(Complete this section ONLY if you are claiming exemption to immunizations.)

If you claim exemption to immunizations, the *Certificate of Exemption* form must be completed by your healthcare provider. You will find the form on our website at http://www.whitworth.edu/Administration/Health&CounselingCenter/Immunization.htm.

You must sign and date the form. If you are under the age of 18, your parent/guardian must sign and date the form.

Please submit the *Certificate of Exemption Form* in addition to your *Health History and Immunization Form*.

Fax or mail to:
Whitworth University Health and Counseling Center
300 West Hawthorne Road
Spokane, WA 99251
Fax: 877.844.1709

Name: _______________________________
Last First MI

Date:___________

TUBERCULOSIS (TB) RISK ASSESSMENT— APPENDIX C

Tool for use by a licensed healthcare provider (MD, DO, ND, PA, ARNP) *in a clinical setting.*
(Have this form completed by a healthcare provider ONLY if you answered "yes" to any of the questions in the Tuberculosis Screening/Testing section.)

HEALTHCARE PROVIDER
TUBERCULOSIS RISK ASSESSMENT

Persons with any of the following are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented:

*Risk Factors:	
Recent close contact with someone with infectious TB disease?	☐No ☐Yes
Foreign-born from (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America)?	☐No ☐Yes
Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease?	☐No ☐Yes
HIV/AIDS diagnosis?	☐No ☐Yes
Organ-transplant recipient?	☐No ☐Yes
Immunosuppressed (equivalent of > 15 mg/day of prednisone for >1 month or TNF-α antagonist)?	☐No ☐Yes
History of illicit drug use?	☐No ☐Yes
Resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facility, nursing home, homeless shelter, hospital, other healthcare facility)?	☐No ☐Yes
Medical condition associated with increased risk of progressing to TB disease if infected [e.g., diabetes mellitus, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal for the given population)]?	☐No ☐Yes

** The significance of the exposure should be discussed and evaluated with a healthcare provider.*

1. **Does the student have signs or symptoms of active tuberculosis disease?** ☐No ☐Yes
   If no, proceed to number 2 or 3. If yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. **Tuberculin Skin Test (TST)**
   *TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "O". The TST interpretation should be based on mm of induration as well as risk factors.***

   Date Given: / /
   M D Y

   Date Read: / /
   M D Y

Name: ________________________________ Date:___________
Last First MI

Result: mm of induration **Interpretation: positive negative

Continued

Date Given: / / Date Read: / /
M D Y M D Y

Result: mm of induration **Interpretation: positive negative

3. **Interferon Gamma Release Assay (IGRA)**—*specify method*

Date Obtained: / /
M D Y

- ☐ QFT-G
- ☐ QFT-GIT
- ☐ T-Spot
- ☐ Other

Result: ☐ negative ☐ positive ☐ indeterminate ☐ borderline—*T-spot only*

Date Obtained: / /
M D Y

- ☐ QFT-G
- ☐ QFT-GIT
- ☐ T-Spot
- ☐ Other

Result: ☐ negative ☐ positive ☐ indeterminate ☐ borderline—*T-spot only*

4. **Chest X-ray**—*required if TST or IGRA is positive*

Date of chest X-ray: / /
M D Y

Result: normal abnormal

See *Interpretation Guidelines* below.

Provider Statement:

I am a qualified and licensed healthcare provider (MD, DO, ND, PA, ARNP). I confirm that I have completed the ***TUBERCULOSIS (TB) RISK ASSESSMENT*** *form for the student named above. I also confirm that I have discussed with the student (or parent or guardian if student is under 18 years of age) information regarding results of any TB testing and further followup or treatments that may be necessary.*

X ______________________________________ / /
SIGNATURE of Licensed Healthcare Provider (MD, DO, ND, PA, ARNP DATE

Please submit the *Tuberculosis (TB) Risk Assessment* form in addition to your *Health History and Immunization Form*.

Fax or mail to:
Whitworth University Health and Counseling Center
300 West Hawthorne Road
Spokane, WA 99251
Fax: 877-844-1709

Name: _______________________________ Date:___________

Last First MI

**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
- Immunosuppressed persons: taking > 15 mg/d of prednisone for > 1 month; taking a TNF-α antagonist
- Persons with HIV/AIDS

>10 mm is positive:

- Persons born in a high-prevalence country or who resided in one for a significant* amount of time
- History of illicit drug use
- Mycobacteriology laboratory personnel
- History of resident, worker, or volunteer in high-risk congregate settings
- Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes

>15 mm is positive:

- Persons with no known risk factors for TB disease

**The significance of the exposure should be discussed and evaluated with a healthcare provider.*

Name: ______________________________ Date:__________
Last First MI

Meningococcal Disease and HPV Information — APPENDIX D

Dear Student, Parent or Guardian:

As of July 1, 2004, colleges and universities in Washington state must make educational information available on meningococcal disease to all incoming students. In addition to information regarding meningococcal disease, Whitworth University also provides educational information on human papillomavirus disease and prevention.

Meningococcal Disease and Prevention

Meningococcal Disease

Meningococcal disease spreads by direct contact with infected persons by coughing, kissing, or sharing anything by mouth, such as water bottles, eating utensils, lipsticks, or toothbrushes. It can cause pneumonia, bloodstream infection, and meningitis (swelling of the covering of the brain and spinal cord). Severe disease can cause brain damage, loss of hearing or limbs, and death. Fortunately, this life-threatening infection is rare – we usually have only about 30-60 cases reported each year in Washington, including one to eight deaths. Adolescents and young adults are more likely to get meningococcal disease, especially if they live in group settings, like college dorms.

Meningococcal Conjugate Vaccine (MCV4)

MCV4 protects your child against the most common types of bacteria that cause meningococcal disease. Patients younger than 19 years of age can get HPV vaccine for free in Washington state. Some healthcare providers' offices charge an administration fee or an office visit fee. You can ask to waive the administration fee if you can't pay. Healthy teens should get one dose of MCV4 during a pre-teen health check up at age 11 thru 12 years. Teens who did not get their first dose during the pre-teen health visit should get a dose as soon as possible. A second dose (or booster) is now recommended. Teens should get a booster at age 16 thru 18 years or anytime before college, but they don't need it if they got the first dose on or after their 16th birthday.Pre-teens/teens aged 11 thru 18 years with high-risk conditions like HIV, absent or defective spleens, and complement-component deficiency may need more doses of this vaccine. Ask your healthcare provider how many doses your adolescent needs for full protection.

Learn More Learn more about meningococcal disease and how to prevent it on the following websites:

Washington State Profile

Meningococcal disease information: www.doh.wa.gov/cfh/immunize/vaccine/meningococcal/default.htm

Centers for Disease Control and Prevention

Meningococcal vaccine information: www.cdc.gov/vaccines/pubs/vis/downloads/vis-mening.pdf
Disease information: www.cdc.gov/meningitis/about/faq.html
Pre-teen immunizations: www.cdc.gov/vaccines/spec-grps/preteens-adol.htm
College students & young adults: www.cdc.gov/vaccines/spec-grps/college.htm

Children's Hospital of Philadelphia Vaccine Education Center

Meningococcus questions & answers: www.chop.edu/vaccine/images/vec_mening_tear.pdf

National Meningitis Association www.nmaus.org

Human papillomavirus (HPV) Disease and Prevention

Human papillomavirus (HPV) Disease

What is HPV?

HPV is a common virus that spreads primarily through sexual contact. Up to 75 percent of HPV infections occur among people 15-24 years old. HPV causes most known cervical cancers, anal cancers, and genital warts. The types of HPV that

can cause genital warts are not the same as the types that cause cancer. Some types of HPV can cause penile, anal, or head and neck cancers.

What are the symptoms of HPV?
Most of the time, infected individuals have no symptoms and can spread the virus without knowing it. Some people know they have HPV because they have a symptom like genital warts. Women may find out they have HPV through cervical cancer screening (Pap tests) and HPV testing. Healthcare providers do not usually test for HPV unless they find abnormal cervical cell changes in a Pap test.

How can HPV infection be prevented?
The best way to prevent HPV infection is to abstain from all sexual activity. Even people with only one lifetime partner can get HPV if their partner had previous sexual partners. Using condoms during sex offers good protection against sexual infections like HPV. The HPV vaccines offer by far the best protection if given before sexual activity starts – vaccines do not get rid of existing HPV infections. The HPV vaccine can prevent infections from some of the most common and serious types of HPV that cause warts and cervical and anal cancers.

HPV Vaccine

What HPV vaccines are available?
Two HPV vaccines are available:

- HPV4 – licensed for males and females. It protects against four types of HPV. These include two types of HPV that cause 75 percent of cervical cancers in women and most anal cancers in men and two types that cause 90 percent of genital warts in both women and men.
- HPV2– licensed only for females. It protects against the two types of HPV that cause 75 percent of cervical cancers.

Who should get the vaccine and when should they get it?

- Females – the federal Advisory Committee on Immunization Practice (ACIP) recommends routine vaccination for all girls age 11-12 years old against HPV. For unvaccinated females, the recommendation goes up through age 26. Healthcare providers may also give the vaccine to girls as young as nine.
- Males – the ACIP recently approved a recommendation for routine vaccination of boys age 11-12 years. For unvaccinated males, the recommendation goes up through age 21. Healthcare providers may vaccinate boys as young as nine years and men aged 22 thru 26 years. The Centers for Disease Control and Prevention will soon make this recommendation available. Until then, healthcare providers may vaccinate males using the permissive recommendation that is in place.

To be up-to-date on this immunization, males and females need three doses of the vaccine. Talk to your healthcare provider about the vaccine schedule. HPV vaccine is not required for school in Washington.

Are Pap tests still recommended for females who get the HPV vaccine?
Yes. The HPV vaccine does not protect against all HPV that can cause cancer and warts, so females still need Pap tests.

Where can I find the HPV vaccine?
Patients younger than 19 years of age can get HPV vaccine for free in Washington state. Some healthcare providers' offices charge an administration fee or an office-visit fee. You can ask to waive the administration fee if you can't pay. For people age 19 and older, the vaccine is available from many clinics and pharmacies. Most health-insurance plans cover the vaccine for people whose physicians recommend that they get it. Call your health plan to check your coverage. For adults without health insurance, the companies that make these vaccines have programs to help pay for them. Find out if your healthcare provider participates in these programs.

For more information on HPV, the Vaccine, and Cervical Cancer:

Centers for Disease Control & Prevention	www.cdc.gov/std/hpv
Washington State Department of Health	www.doh.wa.gov/cfh/immunize/documents/hpvvaccinefactsheet.pdf
American Social Health Association	www.ashastd.org
American Cancer Society	www.cancer.org

Sincerely,

Whitworth University Health Center Staff