



**SAINT LOUIS
UNIVERSITY™**

— EST. 1818 —

Student Health Center
Marchetti Towers East
3518 Laclede Avenue
St. Louis, MO 63103
P: 314-977-2323
F: 314-977-7165
shc@slu.edu

<http://www.slu.edu/student-health-center>

HEALTH HISTORY AND IMMUNIZATION RECORD

Please Print

STUDENT NAME

BANNER ID

PERMANENT ADDRESS

DATE OF BIRTH

CITY, STATE, ZIP

SEX

PHONE

INTENDED MAJOR IF KNOWN

INSTRUCTIONS:

1. Please read the University's Immunization Policy, which is summarized on the back of this document (pages 7 and 8).
2. Complete the form as directed. Please note that the Immunization History should be completed by the health care provider, and signed by a physician.
3. Completed forms must be returned by:
 - August 1 for Fall Semester
 - December 1 for Spring Semester
 - May 1 for Summer Semester

AUTHORIZATION FOR RELEASE OF IMMUNIZATION DATA*

I authorize Saint Louis University to release this immunization record to public health authorities for compliance audits and/ or in the event of a health or safety emergency, and to health care providers and institutions to which I may be assigned during my educational experience if I choose a health professions related major.

STUDENT SIGNATURE

DATE

**Please note that this authorization is for the immunization record only.*



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IMMUNIZATION HISTORY

STUDENT NAME	BANNER ID	DATE OF BIRTH
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TO BE COMPLETED BY HEALTHCARE PROVIDER:

<u>Vaccine or Test</u>	<u>Vaccine Type</u>	<u>Dates(s)</u>	<u>Doctor or Clinic</u>
Polio (PPV or IPV)	_____	Primary Series _____ _____	_____
Diphtheria, Pertussis	_____	Booster Primary Series _____ _____	_____
Tetanus (DPT, DT or Td)	_____	Booster _____ _____	_____
Combination MMR	_____	1 st Dose _____ 2 nd Dose _____	_____
Measles	_____	1 st Dose _____ 2 nd Dose _____	_____
Mumps	_____	_____ _____	_____
Rubella	_____	_____ _____	_____
Meningitis	_____	_____ _____	_____
Varicella	_____	1 st Dose _____ 2 nd Dose _____	_____
Other Vaccines	_____ _____	_____ _____	_____ _____
Physician Clinic Name:	_____		
Address:	_____ _____ _____		
Physician Signature:	_____		Date: _____



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PERSONAL HEALTH HISTORY

STUDENT NAME

BANNER ID

DATE OF BIRTH

TO BE COMPLETED BY STUDENT:

1. Please list any significant current health problems.
2. Please list any medications you take on a regular or frequent basis.
3. Are you allergic to any medications?
 Yes No If yes, please list.
4. Do you have any other kinds of allergic conditions such as asthma, hay fever, etc?
 Yes No If yes, please list.
5. Please list any significant past health problems.
6. Have you ever been hospitalized?
 Yes No If yes, indicate why and when.



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PERSONAL HEALTH HISTORY CONTINUED

7. Have you ever had a head injury, concussion, broken bone or other serious injury?
 Yes No If yes, indicate what injury and when.

8. Have you ever had an operation?
 Yes No If yes, indicate for what and when.

9. Please indicate if you have a history of any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Fainting spells |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Sleep disorder |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Menstrual disorder |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Psychiatric disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alcohol abuse |
| <input type="checkbox"/> Substance Abuse | |

10. Do you have any dietary restrictions for medical reasons?
 Yes No If yes, please specify.

11. Do you have any physical limitations?
 Yes No If yes, please specify.

STUDENT SIGNATURE

DATE



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TUBERCULOSIS SCREENING QUESTIONNAIRE

STUDENT NAME

BANNER ID

DATE OF BIRTH

Please answer the following questions:

- Yes No Have you lived or traveled for >2 months in Asia, Africa, Central or South America, or Eastern Europe?
 Yes No Were you born on one of these continents?
 Yes No Have you ever been vaccinated with BCG?
 Yes No Have you ever had a positive TB skin test or history of active tuberculosis infection?
 Yes No Has anyone living in your household ever had a history of active tuberculosis?
 Yes No Have you worked or volunteered in a nursing home, hospital, homeless shelter, prison, or other health care facility?

If the answer is **NO** to all of the above questions, no further testing or action is required. Please sign below and forward this form with your immunization record to Saint Louis University Student Health Center. A physician's signature is not required on this questionnaire if you answered NO to all the questions.

If the answer is **YES** to any of the above questions, then Saint Louis University requires that a health care provider complete a tuberculosis risk assessment within 6 months prior to the start of class. Results of a tuberculin skin test (PPD) or IGRA blood test such as Quantiferon gold or a T-spot must be provided, unless a previous positive test has been documented. A chest x-ray performed within six months prior to the first day of class is required for a positive PPD or IGRA. A written medical interpretation of the x-ray (in English) must be included.

NOTE: Testing is recommended (but not mandated) for individuals in the following groups:

- HIV positive
 Immunosuppressive disorders from illness or medication (e.g. organ transplants, prednisone)
 History of IV drug abuse or alcoholism
 Students with chronic medical conditions (e.g. diabetes, cancer, kidney disease, malabsorption disorders, etc)

TB (Tuberculin) Skin Test - Date Administered: _____ Date Read: _____ Result: _____mm.

-OR- equivalent blood test result: _____

Chest X-ray required if TB test is positive: Date: _____ Result: NORMAL ABNORMAL

(Attach written medical interpretation of Chest X-ray in English).

Dates of treatment: _____

Physician/ Clinic name: _____

Physician/ Clinic address: _____

Phone number: _____

Physician signature: _____ Date: _____

(Physician signature is only required if providing TB test results, blood test results or chest x-ray).

By signing I attest that the above information is true to the best of my knowledge.

STUDENT SIGNATURE

DATE



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MENINGOCOCCAL VACCINATION REQUIREMENT FOR STUDENTS LIVING ON CAMPUS

REQUIREMENT MUST BE MET BEFORE THE START OF SCHOOL

STUDENT NAME

BANNER ID

DATE OF BIRTH

OPTION #1 VACCINE: To be completed by a health care provider: (Documentation from a physician showing receipt of vaccine or copy of immunization record is also acceptable).

The above named student received meningococcal vaccine on _____

Health Care Provider Name _____ Phone _____

Address _____
Street City State Zip

Signature of provider: _____

OPTION #2 VACCINE WAIVER: to be completed by the individual (or parent/ guardian for individuals less than 18 years of age) requesting an exemption from the requirement.

For individuals 18 years of age or older:

I am 18 years of age or older. I have received and read the information provided by Saint Louis University explaining the risks of meningococcal disease and am aware of the effectiveness and availability of the vaccine at the Student Health Center. I am aware that meningococcal disease is a rare, but life-threatening illness. I understand that Saint Louis University policy requires that freshmen residing in on-campus housing for the first time be vaccinated against meningococcal disease. With this waiver, I seek exemption from this requirement. I voluntarily agree to release, discharge, indemnify and hold harmless Saint Louis University, its officers, employees and agents from any and all costs, liabilities, expenses, claims of causes of action on account of any loss or personal injury that might result from my decision not to be immunized against meningococcal disease.

Student signature: _____ Date: _____

PARENTAL ACKNOWLEDGMENT I have received and read the information provided by Saint Louis University and am aware of the decision of the above-named student regarding vaccination against meningococcal disease.

Name of Parent/ Guardian: _____ Date: _____

Signature of Parent/ Guardian: _____



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SAINT LOUIS UNIVERSITY STUDENT IMMUNIZATION REQUIREMENTS

1. Diphtheria and Tetanus

Documentation of primary series of diphtheria and tetanus toxoid, and a booster within the past ten years.

2. Measles

Documentation of two doses of live measles (or MMR combined) vaccine separated by at least one month on or after the first birthday, or, documentation of physician-diagnosed disease or laboratory evidence of immunity. Individuals who received killed measles vaccine, combination of killed and live measles vaccine, or measles vaccine of an unknown type in the period 1963-1967 are considered unvaccinated, and should receive two doses of live vaccine at least one month apart.

3. Mumps

Documentation of one dose of live mumps (or MMR combined) vaccine on or after the first birthday, or, documentation of physician-diagnosed mumps or laboratory evidence of immunity. Persons who received killed mumps vaccine which was available between 1950-1978 might benefit from revaccination.

4. Rubella

Documentation of one dose of rubella (or MMR combined) vaccine on or after the first birthday, or, documentation of laboratory evidence of immunity.

5. Varicella

Documentation of two doses of live varicella vaccine separated by at least one month, or, documentation of physician-diagnosed disease or laboratory evidence of immunity or birth in U.S. before 1980.

6. Meningitis

Immunization is required for all freshmen students living in residence halls or signed waiver acknowledging risks/benefits of vaccine.

7. Tuberculin Test

Tuberculosis screening is required for all students. Tuberculosis testing is mandated for:

- International students born in a country with a high incidence of tuberculosis.
- Students with a history of living or traveling for more than 2 months in areas with a high incidence of tuberculosis disease.
- Students with signs or symptoms of active tuberculosis, a positive tuberculosis skin test or close contacts with a person known to have active tuberculosis.
- Students who have worked in nursing homes, hospitals, or other residential institutions.

For more information, go to the CDC website.

[http://www.cdc.gov/tb/publications/factsheets/testing/TB_Factsheet.pdf]

8. Hepatitis

Immunization against Hepatitis B is strongly recommended for all students and is required for health professions students prior to their clinical assignments.

9. Polio

Polio vaccine is not routinely given to adults, and therefore students are not required to receive a booster or a primary series if they were not previously immunized. Students should, however, document their childhood polio vaccine immunization. In the unlikely event of epidemic disease, special requirements may be instituted.

Exemptions, applicability, documentation and enforcement are stated on page 8 of this packet.



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EXEMPTIONS:

1. Students claiming exemption from immunizations because of medical contraindications must submit a written statement signed and dated by a physician.
2. Students claiming exemption from immunizations because of religious beliefs must submit a written statement, signed and dated by the student (or parent/guardian if the student is a minor) describing his/her objection to immunization based upon bona fide religious beliefs or practice.

APPLICABILITY, DOCUMENTATION AND ENFORCEMENT:

3. This policy applies to all domestic and international students entering the University for the first time, unless medical or religious exemptions pertain. Students in the School of Professional Studies must only comply with the requirement related to tuberculin testing.
4. Submission of this record, by the date specified, is mandatory. Failure to comply will result in registration being cancelled and/or restricted.
5. The University also reserves the right to deny access to campus facilities, including residence halls, if documentation of compliance has not been provided. Further, in accordance with public health recommendations, non-immune students may be excluded from the University campus in the event of a measles, rubella, mumps or diphtheria outbreak or other public health recommendation.

Meningococcal Vaccines

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 What is meningococcal disease?

Meningococcal disease is a serious bacterial illness. It is a leading cause of bacterial meningitis in children 2 through 18 years old in the United States. Meningitis is an infection of the covering of the brain and the spinal cord.

Meningococcal disease also causes blood infections.

About 1,000–1,200 people get meningococcal disease each year in the U.S. Even when they are treated with antibiotics, 10–15% of these people die. Of those who live, another 11%–19% lose their arms or legs, have problems with their nervous systems, become deaf, or suffer seizures or strokes.

Anyone can get meningococcal disease. But it is most common in infants less than one year of age and people 16–21 years. Children with certain medical conditions, such as lack of a spleen, have an increased risk of getting meningococcal disease. College freshmen living in dorms are also at increased risk.

Meningococcal infections can be treated with drugs such as penicillin. Still, many people who get the disease die from it, and many others are affected for life. This is why preventing the disease through use of meningococcal vaccine is important for people at highest risk.

2 Meningococcal vaccine

There are two kinds of meningococcal vaccine in the U.S.:

- Meningococcal conjugate vaccine (**MCV4**) is the preferred vaccine for people 55 years of age and younger.
- Meningococcal polysaccharide vaccine (**MPSV4**) has been available since the 1970s. It is the only meningococcal vaccine licensed for people older than 55.

Both vaccines can prevent 4 types of meningococcal disease, including 2 of the 3 types most common in the United States and a type that causes epidemics in Africa. There are other types of meningococcal disease; the vaccines do not protect against these.

3 Who should get meningococcal vaccine and when?

Routine vaccination

Two doses of MCV4 are recommended for adolescents 11 through 18 years of age: the first dose at 11 or 12 years of age, with a booster dose at age 16.

Adolescents in this age group with HIV infection should get three doses: 2 doses 2 months apart at 11 or 12 years, plus a booster at age 16.

If the first dose (or series) is given between 13 and 15 years of age, the booster should be given between 16 and 18. If the first dose (or series) is given after the 16th birthday, a booster is not needed.

Other people at increased risk

- College freshmen living in dormitories.
- Laboratory personnel who are routinely exposed to meningococcal bacteria.
- U.S. military recruits.
- Anyone traveling to, or living in, a part of the world where meningococcal disease is common, such as parts of Africa.
- Anyone who has a damaged spleen, or whose spleen has been removed.
- Anyone who has persistent complement component deficiency (an immune system disorder).
- People who might have been exposed to meningitis during an outbreak.

Children between 9 and 23 months of age, and anyone else with certain medical conditions need 2 doses for adequate protection. Ask your doctor about the number and timing of doses, and the need for booster doses.

MCV4 is the preferred vaccine for people in these groups who are 9 months through 55 years of age. MPSV4 can be used for adults older than 55.



4**Some people should not get meningococcal vaccine or should wait.**

- Anyone who has ever had a severe (life-threatening) allergic reaction to a previous dose of MCV4 or MPSV4 vaccine should not get another dose of either vaccine.
- Anyone who has a severe (life threatening) allergy to any vaccine component should not get the vaccine. *Tell your doctor if you have any severe allergies.*
- Anyone who is moderately or severely ill at the time the shot is scheduled should probably wait until they recover. Ask your doctor. People with a mild illness can usually get the vaccine.
- Meningococcal vaccines may be given to pregnant women. MCV4 is a fairly new vaccine and has not been studied in pregnant women as much as MPSV4 has. It should be used only if clearly needed. The manufacturers of MCV4 maintain pregnancy registries for women who are vaccinated while pregnant.

Except for children with sickle cell disease or without a working spleen, meningococcal vaccines may be given at the same time as other vaccines.

5**What are the risks from meningococcal vaccines?**

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of meningococcal vaccine causing serious harm, or death, is extremely small.

Brief fainting spells and related symptoms (such as jerking or seizure-like movements) can follow a vaccination. They happen most often with adolescents, and they can result in falls and injuries.

Sitting or lying down for about 15 minutes after getting the shot—especially if you feel faint—can help prevent these injuries.

Mild problems

As many as half the people who get meningococcal vaccines have mild side effects, such as redness or pain where the shot was given.

If these problems occur, they usually last for 1 or 2 days. They are more common after MCV4 than after MPSV4.

A small percentage of people who receive the vaccine develop a mild fever.

Severe problems

Serious allergic reactions, within a few minutes to a few hours of the shot, are very rare.

6**What if there is a serious reaction?****What should I look for?**

Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or behavior changes.

Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 or get the person to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor might file this report, or you can do it yourself through the VAERS web site at www.vaers.hhs.gov, or by calling **1-800-822-7967**.

VAERS is only for reporting reactions. They do not give medical advice.

7**The National Vaccine Injury Compensation Program**

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at www.hrsa.gov/vaccinecompensation.

8**How can I learn more?**

- Ask your doctor.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
 - Call **1-800-232-4636 (1-800-CDC-INFO)** or
 - Visit CDC's website at www.cdc.gov/vaccines

**Vaccine Information Statement (Interim)
Meningococcal Vaccine**

10/14/2011

42 U.S.C. § 300aa-26

Office Use Only

