



**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>

## REQUIRED HEALTH INFORMATION

*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 5 and 6).
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 if not provided directly from an official electronic health record.
3. Completed forms must be returned by:
  - August 1 for Fall Semester
  - January 3 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

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<b>STUDENT NAME</b>	<b>BANNER ID</b>	<b>DATE OF BIRTH</b>
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**TO BE COMPLETED BY HEALTHCARE PROVIDER:**

<u>Vaccine or Test</u>	<u>Vaccine Type</u>	<u>Date(s)</u>	<u>Doctor or Clinic</u>
Polio	_____	Primary Series _____ _____	_____
		Booster _____	
Tetanus, Diphtheria, Pertussis	_____	Primary Series _____ _____ _____	_____
(Tdap in last 10 years)	_____	Booster _____	_____
Measles, Mumps, Rubella	_____	1st Dose 2nd Dose _____	_____
Meningitis	_____ _____	_____ _____	_____ _____
Varicella	_____	1st Dose 2nd Dose _____	_____
Other Vaccines	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____

Physician Clinic Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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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

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**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: \_\_\_\_\_

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**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 a signed waiver acknowledging risks/benefits of vaccine must be submitted.

### **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](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 6 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:**

1. This policy applies to all domestic and international students unless medical or religious exemptions pertain.
2. Submission of this record, by the date specified, is mandatory. Failure to comply will result in registration being cancelled and/or restricted.
3. 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.