Dear Student:

The staff of the Student Health Service is pleased that you have been offered admission to the University of Delaware. University policy requires that all entering undergraduate and graduate students complete the following forms:

- **MENINGOCOCCAL MENINGITIS VACCINATION OR WAIVER FORM**
  State of Delaware legislation (SB# 175, June 27, 2001) requires recording of your response to information on meningococcal meningitis and availability and benefits of vaccination and your decision to be vaccinated or not to receive the vaccine.

- **PERSONAL AND FAMILY MEDICAL HISTORY FORM**
  This form assists the Student Health Service medical staff to provide quality medical care.

  Please access both the Health History Form and the Meningitis Disease and Vaccination Information form at the following website: [https://www.shsccd.udel.edu/](https://www.shsccd.udel.edu/) or you can go to the Student Health website and select “Secure Access for Students.” The Student Health website is: [http://www.udel.edu/studenthealth/](http://www.udel.edu/studenthealth/)

- **IMMUNIZATION DOCUMENTATION FORM**
  The University of Delaware requires that all entering student must be immunized for measles, mumps and rubella. Students not immunized according to this requirement cannot register at the University of Delaware at the beginning of the next semester.

  All entering students from high risk countries and those entering health care professions must also be screened for tuberculosis with a PPD (Mantoux) Skin Test administered within 6 months prior to beginning classes. (See enclosed Immunization Documentation Form)

**IMMUNIZATION DOCUMENTATION INFORMATION MUST BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER**

Please see the Immunization Record form for information about religious and medical exemptions. Students admitted for the fall term should return the forms in June. Students admitted for the spring term should return the forms in January. If you receive the forms after these dates, please complete and return them as soon as possible. If the forms are not completed and returned, you will not be permitted to register for the next semester.

If you are presently under the care of a physician for chronic disease or other medical condition(s), ask your physician to forward information pertaining both to your medical problem and its treatment to Student Health Service. This will assist in continuity of your care.

The Student Health Service gives allergy injections at regularly scheduled times. Have your physician provide signed detailed instructions. We require that your physician give the first injection of every new vial. We will store your prescribed extract at the Student Health Service.

Federal law prohibits us from making pre-admission inquiries about disabilities. Information regarding disabilities, voluntarily given, will not affect any admission decision. If you require special services because of a disability, you may call the Office of Disabilities Support Services (learning disabilities, ADD or ADHD, other disabilities), 302-831-4643.

Sincerely,

E.F. Joseph Siebold, D.O., F.A.A.P., Physician/Director

* If you will be under age 18 at the time of enrollment it is very important that the Student Health Service have permission from either your parent(s) or guardian(s) to provide medical care until your 18th birthday. Please have one or both of them sign the consent form below:

I hereby grant permission to the Student Health Service of the University of Delaware to render medical care to my dependent ________________________________________ .

<table>
<thead>
<tr>
<th>Name/ Relationship</th>
<th>Name/ Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signed ____________________________ Signed ____________________________

Date ____________________________ Date ____________________________

__ALL MEDICAL RECORDS ARE CONFIDENTIAL__

— OVER —
* THIS INFORMATION MUST BE COMPLETED OR FORM WILL BE RETURNED.

* INSURANCE:

If you do NOT have health insurance check here. ☐

- Is the primary insurance plan considered a Health Care Maintenance Organization (HMO) or Preferred Provider Organization (PPO)?
  ☐ Yes ☐ No
- Does the primary insurance plan require authorization or pre-certification for diagnostic testing?
  ☐ Yes ☐ No

Special Considerations:

- Many insurance plans pay reduced or no benefits for “out-of-network” providers. If your provider network is outside the immediate Newark, Delaware area, please request “away from home” benefits from your insurance carrier before your student leaves home.

Student Health Services uses “LabCorp” for outside laboratory tests. Does your insurance company participate with them?
  ☐ Yes ☐ No If no, which laboratory does your insurance provider participate with? ____________________________

PLEASE INCLUDE A COPY OF FRONT AND BACK OF YOUR MEDICAL INSURANCE CARD AND PRESCRIPTION INSURANCE CARD.

Include a copy of the front and back of your medical insurance and prescription cards here.

STUDENTS SHOULD ALSO HAVE THEIR OWN PERSONAL COPY OF THESE CARDS.

Plan to enroll: ☐ Fall 20____  ☐ Winter 20____  ☐ Spring 20____  ☐ Summer 20____

Classification: ☐ Freshman ☐ Associate in Arts ☐ Transfer
☐ Re-admit ☐ Graduate ☐ Other

____________________________________________________________ _________________________________
STUDENT’S SIGNATURE                        Date
IMMUNIZATION DOCUMENTATION

ALL OF THE FOLLOWING INFORMATION MUST BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PRACTITIONER. IF THIS FORM IS NOT COMPLETE, YOU WILL NOT BE PERMITTED TO REGISTER FOR THE NEXT SEMESTER. A PHYSICAL EXAMINATION IS NOT REQUIRED. ALL INFORMATION MUST BE IN ENGLISH. PLEASE PRINT.

Student Name ___________________________________________________________

Date of Birth ___/____/_______  UD ID # ________________________________

Country of Birth ___________________________ If not USA, indicate when you entered this country M/Y

1. REQUIRED – ALL STUDENTS

The University of Delaware requires evidence of immunity to Measles, Mumps, and Rubella for students entering the University. Students born before January 1, 1957 are exempt from the MMR requirement.

MMR (Measles, Mumps, Rubella) (Two doses required.) Dose 1 given at age 12-15 months or later — Dose 2 given at age 4-6 years or later, and at least one month after first dose.

MMR Dates #1 ______/____/____, #2 ______/____/___ /OR

Measles Dates ______/____/____, ______/____/_____ /or Disease Date ______/____/____ /or Antibody Date Titer ______/____/____ *

Mumps Dates ______/____/____, ______/____/_____ /or Disease Date ______/____/____ /or Antibody Date Titer ______/____/____ *

Rubella Dates ______/____/____, ______/____/_____ /or Disease Date Not Acceptable /or Antibody Date Titer ______/____/____ *

*Enclose copy of lab report

2. REQUIRED – ALL STUDENTS

Decision required for meningococcal meningitis vaccination or waiver using online form.

3. REQUIRED INFORMATION - ALL STUDENTS

3A - TUBERCULOSIS (TB) RISK QUESTIONNAIRE

1. Have you ever had a positive tuberculin skin test or blood test in the past? ☐ Yes ☐ No

2. To the best of your knowledge have you ever had close contact with anyone who was sick with tuberculosis (TB)? ☐ Yes ☐ No

3. Were you born in a country NOT listed below and arrived in the U.S. within the past 5 years? * ☐ Yes ☐ No

4. Have you traveled or lived for more than one month in any country NOT listed below? * ☐ Yes ☐ No

5. Have you ever had changes on a prior chest x-ray suggesting inactive or past TB disease? ☐ Yes ☐ No

6. Do you have a medical condition associated with increased risk of progressing to TB disease if infected such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, HIV/AIDS, gastronomy or intestinal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone >15mg/day for >1 month), other immunosuppressive disorders, or are you an organ transplant recipient? ☐ Yes ☐ No

7. Have you been a volunteer, employee or resident in a high-risk congregate setting such as a prison, nursing home, hospital, homeless shelter, residential facility or other health care facility in the past 12 months? ☐ Yes ☐ No

8. Do you have a history of illicit drug use? ☐ Yes ☐ No

* USA American Samoa Australia Belgium Canada Denmark Iceland Luxembourg Norway Switzerland

American Samoa Denmark Iceland Luxembourg Norway Switzerland

Australia Finland France Germany Greece

Belgium Ireland Italy Liechtenstein New Zealand Norway

Canada Iceland Italy Luxembourg Sweden

* Other countries in Europe not listed above.

3B - If you answer NO to all of the above questions, no further action is required. If you answer YES to any of the above questions, you are a candidate for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), within 6 months prior to beginning classes, unless a previous positive test has been documented. Prior BCG does not exempt students from the requirement.

3C - TB SKIN TEST Use Mantoux test only

<table>
<thead>
<tr>
<th>Date Planted:</th>
<th>Interpretation: Neg. ☐ Pos. ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td><em><strong>/</strong>__/</em>___</td>
<td>mm induration</td>
</tr>
</tbody>
</table>

Date Read: ___/____/____ |

(If no induration, mark “0”)

3D - CHEST X-RAY

<table>
<thead>
<tr>
<th>Chest X-Ray Date:</th>
<th>Result: Neg. ☐ Pos. ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td><em><strong>/</strong>__/</em>___</td>
<td>Normal ☐ Abnormal</td>
</tr>
</tbody>
</table>

*Enclose copy of lab report

3E - MEDICATION TREATMENT FOR TUBERCULOSIS:

Drug: __________________

Dose and Frequency: __________________

Treatment completion date: ___/____/____

See reverse side of form for additional immunization history, religious/medical exemption and practitioner’s signature.
**RECOMMENDED IMMUNIZATIONS** - *(Must complete Meningitis decision form)*

### MENINGOCOCAL MENINGITIS VACCINE
- Menactra® Vaccine Date: ____________________________
- Menomune® Vaccine Date: ____________________________
- Menevo® Vaccine Date: ____________________________

### TETANUS-DIPHTHERIA-PERTUSSIS
- Completed primary series of tetanus-diptheria-pertussis immunizations: ____________________________
- Received tetanus-diptheria booster within last 10 years: ____________________________
- Booster: Tdap (preferred) to replace a single dose of Td for booster immunization with at least 2-5 years since last dose of Td, depending on age of patient. (Administer with MCV4 simultaneously if possible): ____________________________

### POLIO (POLIOMYELITIS)
- Completed primary series of polio immunization: ____________________________
- Last booster: ____________________________

### HEPATITIS A
- Dates #1: ____________________________, #2: ____________________________

### HEPATITIS B
- Dates #1: ____________________________, #2: ____________________________, #3: ____________________________
- Surface antibody Result: Reactive___ Non Reactive___

### COMBINED HEPATITIS A and B VACCINE
- Dates #1: ____________________________, #2: ____________________________, #3: ____________________________

### HPV
- Cervarix®: ____________________________, Gardasil®: ____________________________

### VARICELLA (Chicken Pox)
- Dates #1: ____________________________, #2: ____________________________, or Disease Date: ____________________________
- Antibody Date Titer: ____________________________
- Result: Reactive___ Non Reactive___

### OTHER
- Date: ____________________________
- Other: ____________________________

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**Health Care Practitioner (Physician, Nurse Practitioner, P.A., Nurse)**

Name: _____________________________________________________
Address: ___________________________________________________
Signature: ____________________________________
Phone (________) ________________________________

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**EXEMPTIONS**

**MEDICAL EXEMPTION**  
________________________________________ should be exempt from some of the mandatory immunization requirements noted on the University of Delaware Student Health Service Immunization Record (see reverse side). Administration of the following immunizing agents would be detrimental to this student’s health:

Physician’s Signature: ________________  Date: ________________
Physician’s Printed Name: ____________________________
Physician’s Address: ____________________________

**RELIBGIOUS EXEMPTION**

I, ____________________________, wish to be exempt from the mandatory immunization requirements noted on the University of Delaware Student Health Service Immunization Record (see reverse side), because of my religious beliefs. I release the University of Delaware and its employees from any responsibility for any impairment of my health resulting from this exemption.

Student’s Signature: ____________________________  Date: ________________
Clergy’s Signature: ____________________________
Clergy’s Printed Name: ____________________________

Rev. 04/10