



**TO THE EXAMINING PHYSICIAN OR HEALTHCARE PROVIDER:** We appreciate your thoroughness in reviewing the patient's medical history and completing **PAGES 2 THROUGH 4** of this form -- including a physical examination (within the 12 months prior to matriculation), tuberculosis screening and documentation of immunizations. **SIGN ALL 3 PAGES.**

**Date of Examination** \_\_\_\_/\_\_\_\_/\_\_\_\_ (Must be within 12 months of entering school)  
mm/dd/yyyy

**STUDENT NAME** \_\_\_\_\_ **Gender** \_\_\_\_\_  
LAST FIRST M.I.

**Weight** \_\_\_\_\_ **Height** \_\_\_\_\_ **Blood Pressure** \_\_\_\_\_ **Pulse** \_\_\_\_\_

**Evaluate the following systems and note abnormalities:**  
**NORMAL** (☑) **ABNORMAL FINDINGS** (Explain)

Head, Ears, Nose or Throat
Respiratory
Cardiovascular
Gastrointestinal
Eyes (Refractive)
Eyes (Other)
Genitourinary
Musculoskeletal
Metabolic/Endocrine
Skin
Joint Function

**Is student being treated for any medical conditions?**  
\_\_\_\_\_  
\_\_\_\_\_

**Is the student being treated for any psychological conditions?**  
\_\_\_\_\_  
\_\_\_\_\_

**Name and dosage of current medications:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Name of Physician or Healthcare Provider **PRINTED** or office stamp

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician or Healthcare Provider

**CONTINUED ON NEXT PAGE**

**TUBERCULOSIS SCREENING: Questions 1 & 2 Required; Actual testing may not be necessary but form MUST BE COMPLETED AND SIGNED BY A HEALTHCARE PROVIDER within the 6 months prior to matriculation.**

**STUDENT NAME** \_\_\_\_\_ **Date of screening** \_\_\_\_\_  
LAST FIRST M.I. mm/dd/yyyy

1. **Does the student have signs or symptoms of active TB disease? Check one** (Unexplained persistent cough, night sweats, weight loss, chills or fever, fatigue, hemoptysis, loss of appetite or exposure to TB) **Check one**

**NO**, Proceed to Question 2.

**YES**, Proceed to Item 3, additional evaluation required to exclude active TB disease (including Tuberculin skin testing, IGRA, chest x-ray and sputum evaluation, as indicated).

2. **Was the student born in or recently arrived from a country other than those listed below\* or a member of a high-risk group\*\*? Check one**

**NO, SIGN AND DATE BOTTOM OF PAGE.** Do not perform a TB skin test.

**YES, Check one or more below, as appropriate.** Then proceed to Item 3

If no previous positive test then Mantoux must be administered within 6 months of matriculation.

If prior positive Mantoux test, Date of Positive TB test \_\_\_\_/\_\_\_\_/\_\_\_\_, then Interferon Gamma Release Assay (IGRA) or chest x-ray required, mm/dd/yyyy

A history of BCG vaccination should not preclude testing of a member of a high-risk group; If patient has received BCG provide date of last dose BCG \_\_\_\_/\_\_\_\_/\_\_\_\_. mm/dd/yyyy

\*Categories of high-risk students include those students who have arrived within the past 5 years or were born in countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: American Samoa, Andorra, Antigua and Barbuda, Aruba, Australia, Austria, Bahamas, Bahrain, Barbados, Belgium, Bermuda, Bonaire, British Virgin Islands, Canada, Cayman Islands, Chile, Cook Isl., Costa Rica, Croatia, Cuba, Curacao, Cyprus, Czechia, Denmark, Dominica, Egypt, Estonia, Finland, France, Germany, Greece, Grenada, Hungary, Iceland, Iran, Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Luxembourg, Malta, Mauritius, Monaco, Montenegro, Montserrat, Netherlands, New Zealand, New Caledonia, Norway, Oman, Poland, Puerto Rico, Saint Eustatius, Saint Kitts and Nevis, Saint Lucia, Saint Vincent, Samoa, San Marino, Saudi Arabia, Serbia, Seychelles, Sint Maarten, Slovakia, Slovenia, Spain, Sweden, Switzerland, Syrian Arab, The Former Yugoslav Repub. of Macedonia, Tokelau, Tonga, Trinidad and Tobago, Turkey, Turks and Caicos Islands, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, USA, US Virgin Isl., Wallis and Futuna Isles., West Bank and Gaza Strip.

\*\*Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy ( e.g. prednisone  $\geq$  15 mg/d for  $\geq$  1 month ) or other immunosuppressive disorders.

3. **If question 1 or 2 YES, Mantoux Tuberculin skin test Or Interferon Gamma Release Assay (IGRA) required** (within 6 months of matriculation)

TB Skin test: Date given: \_\_\_\_/\_\_\_\_/\_\_\_\_ (must be within 6 months of matriculation)  
mm/dd/yyyy

Date read: \_\_\_\_/\_\_\_\_/\_\_\_\_ **Result:** \_\_\_\_\_ mm (Record mm of induration, transverse diameter, if no induration write "0")  
mm/dd/yyyy

Interpretation:  positive  negative (based on mm of induration as well as risk factors)

IGRA: Date Obtained: \_\_\_\_/\_\_\_\_/\_\_\_\_ Attach copy of results/lab report  
mm/dd/yyyy

4. **Chest X-ray** (required if tuberculin skin test or IGRA is positive): Date of chest x-ray: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm/dd/yyyy

Result:  normal  abnormal

**Does the patient require additional follow up or treatment for Latent TB Infection?** \_\_\_\_\_

**VERIFICATION OF SCREENING BY HEALTH CARE PROVIDER**

\_\_\_\_\_  
 Signature of Healthcare Provider Date Printed Name or Office Stamp  
 The American College Health Association has published guidelines on tuberculosis screening of college and university students. These guidelines are based on recommendations from Centers for Disease Control and the American Thoracic Society. For more information, visit [http://www.acha.org/documents/resources/guidelines/ACHA\\_Tuberculosis\\_Screening.pdf](http://www.acha.org/documents/resources/guidelines/ACHA_Tuberculosis_Screening.pdf) or refer to the CDC's Core Curriculum on Tuberculosis <http://www.cdc.gov/tb/education/corecurr/index.htm>. **CONTINUED ON NEXT PAGE**

**IMMUNIZATIONS REQUIRED. TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER or attach an official copy of the student's immunization records.**

**STUDENT NAME** \_\_\_\_\_  
LAST FIRST M.I.

**Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm/dd/yyyy

**TRINITY ID #** \_\_\_\_\_

**Required vaccines:**

**For All Students under 22 years of age**

- **MENINGOCOCCAL TETRAVALENT Conjugate (MCV4)** (Preferred) Date \_\_\_\_/\_\_\_\_/\_\_\_\_ mm/dd/yyyy **Must be within the 5 years prior to the first day of classes.**  
**OR Polysaccharide vaccine (MPSV4)** Date \_\_\_\_/\_\_\_\_/\_\_\_\_ mm/dd/yyyy

*Texas law requires this vaccination to be received at least 10 days before the start of class and within the 5 years preceding the first day of class. (May attach required documentation) See guidelines at [http://inside.trinity.edu/sites/inside.trinity.edu/files/file\\_attachments/24/trinityu-meningitis-vaccine-guidelines-oct-13.pdf](http://inside.trinity.edu/sites/inside.trinity.edu/files/file_attachments/24/trinityu-meningitis-vaccine-guidelines-oct-13.pdf)*

**For All Students living on campus**

- **POLIO (IPV/OPV)** Date \_\_\_\_/\_\_\_\_/\_\_\_\_ mm/dd/yyyy  
*Date required if under 18 years of age*
- **TETANUS-DIPHTHERIA (Td)** Date \_\_\_\_/\_\_\_\_/\_\_\_\_ mm/dd/yyyy  
**OR TETANUS-DIPHTHERIA-PERTUSSIS (Tdap)** Date \_\_\_\_/\_\_\_\_/\_\_\_\_ mm/dd/yyyy  
*Must have received within past ten (10) years*
- **MEASLES, MUMPS, RUBELLA (MMR)** (two doses required)  
**Dose 1** \_\_\_\_/\_\_\_\_/\_\_\_\_ mm/dd/yyyy **Dose 2** \_\_\_\_/\_\_\_\_/\_\_\_\_ mm/dd/yyyy  
*(Given at age 12-15 months or later) (Given at age 4-6 years or later, and at least one month after first dose)*

**Recommended vaccines:** Students are encouraged to have these vaccinations but they are not required. Record all dates as mm/dd/yyyy

- **HEPATITIS B VACCINE**

Dose 1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose 2 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose 3 \_\_\_\_/\_\_\_\_/\_\_\_\_

- **HEPATITIS A VACCINE**

Dose 1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose 2 \_\_\_\_/\_\_\_\_/\_\_\_\_

- **VARICELLA** (If no history of Chicken Pox or negative Varicella Antibody)

Dose 1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose 2 \_\_\_\_/\_\_\_\_/\_\_\_\_ (given at least one month after first dose, if age 13 years or older)

- **Human Papillomavirus Vaccine, 4vHPV, 9vHPV, OR Bivalent, Please circle one**

Dose 1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose 2 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose 3 \_\_\_\_/\_\_\_\_/\_\_\_\_

- **MENINGOCOCCAL SEROGROUP B** Circle one: MenB-RC (Bexsero, 2 doses) or MenB-FHpb (Trumenba, 2 or 3 doses)  
For students at increased risk, Must complete series with same vaccine

Dose 1 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose 2 \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose 3 (if needed) \_\_\_\_/\_\_\_\_/\_\_\_\_,

**VERIFICATION OF IMMUNIZATIONS BY HEALTHCARE PROVIDER**

Signature of Healthcare Provider \_\_\_\_\_ Date mm/dd/yyyy \_\_\_\_\_ Printed Name or Office Stamp \_\_\_\_\_

When all 4 pages are complete and signed, return this form with a copy of the front and back of your personal health insurance card to:  
**TRINITY UNIVERSITY HEALTH SERVICES** **PHONE: (210) 999-8111**  
**ONE TRINITY PLACE #80** **FAX: (210) 999-8378**  
**SAN ANTONIO, TEXAS 78212-4674** **EMAIL: healthservices@trinity.edu**

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