

UNIVERSITY OF DELAWARE - STUDENT HEALTH SERVICE  
LAUREL HALL, NEWARK, DELAWARE 19716-8101  
(302) 831-2226 FAX (302) 831-6407

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.shccsd.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/>

• **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**

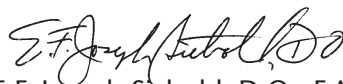
Please see the Immunization Record form for information about religious and medical exemptions. Students admitted for the **fall term** should return the forms in **June**. Students admitted for the **spring term** should return the forms in **January**. If you receive the forms after these dates, please 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 \_\_\_\_\_.

(Name of Student)

Name/  
Relationship \_\_\_\_\_ / \_\_\_\_\_

Name/  
Relationship \_\_\_\_\_ / \_\_\_\_\_

Signed \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_

**ALL MEDICAL RECORDS ARE CONFIDENTIAL**

\* **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 \_\_\_\_\_  
Last First Middle

Date of Birth \_\_\_\_\_ UD ID # \_\_\_\_\_  
Month Day Year

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  
M D Y M D Y

Measles Dates \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_ /or Disease Date \_\_\_\_/\_\_\_\_ /or Antibody Date Titer \_\_\_\_/\_\_\_\_/\_\_\_\_\*  
M D Y M D Y M Y M D Y

Mumps Dates \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_ /or Disease Date \_\_\_\_/\_\_\_\_ /or Antibody Date Titer \_\_\_\_/\_\_\_\_/\_\_\_\_\*  
M D Y M D Y M Y M D Y

Rubella Dates \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_ /or Disease Date Not Acceptable /or Antibody Date Titer \_\_\_\_/\_\_\_\_/\_\_\_\_\*  
M D Y M D Y M Y M D Y

\*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 tuberculosis 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, gastrectomy 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	Denmark	Iceland	Luxembourg	Norway	Switzerland
American Samoa	Finland	Ireland	Malta	Saint Kitts and Nevis	United Kingdom
Australia	France	Italy	Monaco	Saint Lucia	Virgin Islands (USA)
Belgium	Germany	Jamaica	Netherlands	San Marino	
Canada	Greece	Liechtenstein	New Zealand	Sweden	

**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 **-OR-** **TB BLOOD TEST**

Date Planted: ____/____/____ <small>M D Y</small>	Interpretation: Neg. <input type="checkbox"/> Pos. <input type="checkbox"/> ____mm induration (If no induration, mark "0")	Quantiferon: <input type="checkbox"/> Other: _____ Date : ____/____/____ <small>M D Y</small> Result: Neg. <input type="checkbox"/> Pos. <input type="checkbox"/> *Enclose copy of lab report
Date Read: ____/____/____ <small>M D Y</small>		

**3D - CHEST X-RAY**

Chest X-Ray Date :  
\_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y

Normal  Abnormal

**3E - MEDICATION TREATMENT FOR TUBERCULOSIS:**

Drug: \_\_\_\_\_

Dose and Frequency: \_\_\_\_\_

Treatment completion date:  
\_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y

**RECOMMENDED IMMUNIZATIONS - (Must complete Meningitis decision form)**

**MENINGOCOCCAL MENINGITIS VACCINE**

- Menactra® Vaccine Date.....     /    /      
(MCV4) M          D          Y
- Menomune® Vaccine Date.....     /    /      
(MPSV4) M          D          Y
- Menveo® Vaccine Date.....     /    /      
M          D          Y

**+TETANUS-DIPHTHERIA-PERTUSSIS**

- Completed primary series of tetanus-diphtheria-pertussis immunizations.....     /    /      
M          D          Y
- Received tetanus-diphtheria booster within last 10 years .....     /    /      
M          D          Y
- 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).....     /    /      
M          D          Y

**+POLIO (POLIOMYELITIS)**

- Completed primary series of polio immunization.....     /    /      
M          D          Y
- Last booster .....     /    /      
M          D          Y

**HEPATITIS A** Dates #1     /    /    , #2     /    /      
M          D          Y          M          D          Y

**+HEPATITIS B** Dates #1     /    /    , #2     /    /    , #3     /    /      
M          D          Y          M          D          Y          M          D          Y

**HEPATITIS B** surface antibody Result: Reactive      Non Reactive          /    /      
M          D          Y

**COMBINED HEPATITIS A and B VACCINE** Dates #1     /    /    , #2     /    /    , #3     /    /      
M          D          Y          M          D          Y          M          D          Y

**HPV**  Cervarix®  Gardasil® Dates #1     /    /    , #2     /    /    , #3     /    /      
M          D          Y          M          D          Y          M          D          Y

**+VARICELLA (Chicken Pox)** #1     /    /    , #2     /    /     / or Disease Date     /    /      
M          D          Y          M          D          Y          M          Y

Antibody Date Titer:     /    /     Result: Reactive      Non Reactive       
M          D          Y

**OTHER** \_\_\_\_\_ Date     /    /     **OTHER** \_\_\_\_\_ Date     /    /      
M          D          Y          M          D          Y

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

Name \_\_\_\_\_ Address \_\_\_\_\_  
(Print Clearly)

Signature \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

+ Note: If you are a student entering the health professions or you are an education major, some of these immunizations or proof of immunity (Antibody Titer) are required for clinical training or student teaching.

**EXEMPTIONS**

**MEDICAL EXEMPTION**

\_\_\_\_\_ should be exempt from some of the  
(Print Name of Student)  
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 \_\_\_\_\_

**RELIGIOUS EXEMPTION**

I, \_\_\_\_\_ wish to be exempt from the mandatory  
(Print Name of Student)  
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 \_\_\_\_\_