

# 2008-2009 Annual Health Update Form

## University at Buffalo Student Health Services

Michael Hall, 3435 Main Street, Buffalo, NY 14214-8003

*The entire form needs to be completed annually by all students in health related academic programs. The MMR series, a PPD within the past 12 months, Tetanus within the past 10 years, a completed Hepatitis B Series, and a completed Varicella series/disease history are all **REQUIRED** for students in the health related academic programs/majors.*

You may obtain any of the vaccines/tests on this page from your primary care provider or UB Student Health Services. An RN, PA, NP, or MD/DO must sign at the bottom of this page. To schedule an appointment with Student Health Services, please call 829-3316. To find out more information on the requirements for students in the health related academic programs/majors or on the various vaccines/tests and their costs, please go to <http://www.student-affairs.buffalo.edu/shs/student-health/immunization.shtml>.

**If completed by a provider other than Student Health Services, please make a copy of the completed form for your records and then return it to the above address.**

Has there been any significant illness/injury in the last 12 months? **YES NO** (Circle)

If yes, please describe/specify and note where the student will be following up for care:

Immunization	Vaccine Date Month/Day/Year	Or Physician Diagnosed Disease/Date Of Onset	Or Serology Results/Date Note whether immune
<b>MEASLES</b> (2 shots) (Note: 1 <sup>st</sup> shot given after 1 <sup>st</sup> birthday & 2 <sup>nd</sup> shot at least 28 days after first shot)	#1		Attach lab results
	#2		
<b>MUMPS</b>			Attach lab results
<b>RUBELLA</b>			Attach lab results
<b>Or 2 MMR's</b> (2 Measles, Mumps, and Rubella combination shots can replace the above)	#1		
	#2		
<b>PPD (Mantoux)</b> (Tine Test Not Accepted)  Within the last 12 months unless prior history of positive PPD. *Required if positive PPD	Date Placed: (Month/Day/Year)	Date Read 48-72 Hours Later: (Month/Day/Year)	Results:  mm of induration
	Chest X-Ray Date *		Results
	If negative CXR and Positive PPD, did you complete a course of INH? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," how many months did you take INH? (# of months)		
<b>TETANUS</b> Within 10 yrs. (mm/dd/yy)	Circle: Td or Tdap		
<b>HEPATITIS B</b> (month/day/year)	#1	#2	#3
<b>VARICELLA</b> (month/day/year)	#1	#2	<b>OR</b> Date of Chicken Pox Disease

Student's name (please print): \_\_\_\_\_ UB Person #: \_\_\_\_\_  
Last
First
MI

Birthdate (mm/dd/yyyy): \_\_\_\_\_ Academic Program/Major: \_\_\_\_\_

Date form filled out: \_\_\_\_\_ Country of Birth: \_\_\_\_\_

Signature of medical provider: \_\_\_\_\_

Phone number of medical provider: \_\_\_\_\_