

2009-2010 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. You may obtain any of the vaccines/tests listed on this form from your primary care provider or at UB Student Health Services. To schedule an appointment with UB Student Health Services, please call 829-3316. To find out more information on the requirements, please go to <http://www.student-affairs.buffalo.edu/shs/student-health/immunization.shtml>.

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

If yes, please describe _____

| Immunization/ Vaccination | Vaccine Date Month/Day/Year | Or Physician Diagnosed Disease(note date of onset) | Or Serology/Titer (note results & date) |
|--|--|--|--|
| 2 MMR'S (combo measles, mumps & rubella vaccine) 1 st dose after 1 st birthday; 2 nd dose at least 28 days later. (OR list individual vaccines below) | #1 | N/A | N/A |
| | #2 | | |
| 2 MEASLES 1 st dose after 1 st birthday; 2 nd dose at least 28 days later | #1 | | Attach lab results and/or note whether immune |
| | #2 | | |
| 1 MUMPS after 1 st birthday | | | Attach lab results and/or note whether immune |
| 1 RUBELLA after 1 st birthday | | History of rubella disease does not prove immunity | Attach lab results and/or note whether immune |
| PPD (Tuberculosis skin test) Within the last 12 months. If PPD is contraindicated due to history of past positive result, must provide date and measurement of the past positive PPD. Individuals with history of positive PPD must also complete sections marked with a * | Date Placed: (Month/Day/Year) | Date Read (Month/Day/Year) <small>(Must be 48-72 hours after placement)</small> | Results/measurement: _____ mm of induration |
| | *Chest X-Ray Date: | | *Chest X-Ray Results: |
| | *If positive PPD & normal chest x-ray, did the patient take INH? (circle) Y N | | |
| | If "Y" for how many months did the patient take INH? _____ months | | |
| | <i>The following questions are mandatory for patients with history of positive PPD:</i> *Have you had loss of appetite, or unexplained weight loss in the past year? Y N *Have you had a persistent low-grade fever or night sweats over the past year? Y N *Have you had an unusual, persistent productive cough lasting more than 2 weeks, or have you coughed up blood at any point in the past year? Y N <i>If patient answers yes to any of the above questions, refer to MD/DO/NP/PA for evaluation</i> | | |
| TETANUS Within 10 yrs. (month/day/year) | Circle: Td or Tdap | | |
| HEPATITIS B (month/day/year) | #1 | #2 | #3 |
| VARICELLA (month/day/year) | #1 | #2 | OR Year patient had 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 (RN,PA,NP,MD,or DO): _____

Phone number of medical provider: _____