Student Name: ____

Tompkins Cortland Community College
PO Box 139, Dryden, New York 13053
fax: 607.844.6533 | phone: 607.844.8222, Ext. 4487

Health Services Immunization and Health Information Form

Your complete record for required vaccines (Part II) must be on file in our Health Center before the start of classes or you will be MEDICALLY WITHDRAWN FROM CLASSES per NYS Public Health Laws 2165 and 2167. Please contact Health Services with any questions. (607.844.8222, Ext.4487) or refer to our website for further information: https://www.tompkinscortland.edu/campus-life/health-center

PART I: TO BE COMPLETED BY STUDENT

Name ______________________ ______________________ ______________________
First Name Middle Name Last Name

Address ____
Street City S tate Zip

Semester/year of enrollment ____/________ Date of Birth ____/____/________ School ID# ______________________
M Y M D Y

PART II: TO BE COMPLETED BY PARENT IF STUDENT IS UNDER 17 YEARS OLD:

STUDENT TREATMENT PERMISSION

I grant permission for Tompkins Cortland Community College Health Services to provide medical care and immunizations to the above student as necessarh3.521

meningococcal meningitis disease. I understand the risks of not receiving the vaccine.

Student signature: ____ Date______________________
(Parent os guardian signature if student under 18 years of age)

REQUIRED IMMUNIZATIONS

A. MMR (MEASLES, MUMPS, RUBELLA) (Two doses required at least 28 days apart for students born after 1957.)

1. Dose 1 given at age 12 months or later . ... #1 Date __________________

2. Dose 2 given at least 28 days after first dose . ... #2 Date __________________

or

Positive antibodies for Measles, Mumps, and Rubella. **ATTACH COPY OF LAB RESULTS**

B. MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135) One dose within the last 5 years or a completed 2-dose series. (Not required if above declination is signed)

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).
a. Dose #1 Date __________________ b. Dose #2 Date __________________

2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available).

Provider signature ____ Date ______________________

C. TETANUS, DIPHTHERIA, PERTUSSIS

1. Date of last dose in series: ____/____/________
M D Y

2. Date of most recent booster dose: ____/____/________ Type of booster: Td _____ Tdap _____

Tdap booster recommended for ages 11-64 unless contraindicated

D. VARICELLA (A positive varicella antibody or two doses of varicella vaccine)

1. Positive varicella antibody. ATTACH COPY of LAB RESULTS

2. Immunization

a. Dose #1 . ... #1 ____/____/________

b. Dose #2 given at least 12 weeks after first dose ages 1–12 years... #2 ____/____/________
and at least 4 weeks after first dose if age 13 years or older.

1. TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? ❑ Yes ❑ No If No, proceed to 2 or 3

If yes, check below:

❑ Cough (especially if lasting for 3 weeks or longer) with or without sputum production

❑ Coughing up blood (hemoptysis)

❑ Chest pain

❑ Loss of appetite

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0".
The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ____/____/____ Date Read: ____/____/____
M D Y M D Y

Result: ________ mm of induration **Interpretation: positive____ negative____

Date Given: ____/____/____ Date Read: ____/____/____
M D Y M D Y

Result: ________ mm of induration **Interpretation: positive____ negative____

3. Chest x-ray: (REQUIRED IF TST OR IGRA IS POSITIVE)

Date of chest x-ray: ____/____/____ Result: normal____ abnormal_____
M D Y

Management of Positive TST or IGRA

All students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- Infected with HIV
- Recently infected with M. tuberculosis (within the past 2 years)
- History of untreated or inadequately treated TB disease, including persons with fibroRcscheng eson chest xrnRmB wi(Mth fibroRcs pe7LangbroRcs 355BT