From the Health Services Office

Welcome to Moore College of Art & Design. Health Services is located on the first floor of Stahl Hall. Diane Azuma, Moore's Registered Nurse, is available during the fall and spring semesters to meet students' routine health care needs and to handle emergencies. Health Services is open Monday through Friday from 9am-3pm.

Counseling Services
In addition to the coverage for your physical needs, Student Services also has a college counselor, Ruth Gayle, who has been working with Moore women and artists for over 15 years. She is available Mondays, 11am-6pm; Wednesdays, 12pm-6:30pm & Fridays, 11am-5:30pm. Ruth Gayle also makes referrals to off-campus therapists or psychiatrists and handles psychological emergencies in conjunction with other relevant staff members or administration.

Health Insurance
Moore College requires that all students have health insurance. If you are insured under your family's health plan, you will need to submit documentation of coverage. The link to the health insurance waiver will be made available via Moodle on the New Student Guide. For students without coverage, you will need to purchase Moore's insurance. Note, if you do not fill out the waiver or opt-out form, you will be automatically enrolled in Moore's insurance.

Health Form
Enclosed in this letter is the health form. It is your responsibility to have this form completed, signed by your physician, and returned to the health services office. You must see a doctor in order to fill out sections of this form, so make sure to make an appointment as soon as possible. It can sometimes take several weeks or even a month to get an appointment.

What you need to include with the Health Form
In order to ensure that each section is thoroughly completed, you will find a checklist in the packet that outlines which sections you and your doctor must fill out. You must also include the following and attach it to this form:
- Your immunization record
- A copy (front and back) of your health insurance card

Due Dates
It is very important that you complete the health form and have it sent in by the dates listed below. The due date is contingent upon whether you live on or off campus. Failure to return a completed health form will result in a $100 penalty, and a hold will be placed on your student account.

- Incoming Residents: Your health form is due August 1, 2016. Residents without completed health forms may not move into housing.
- Commuter Students: Your health form is due September 12, 2016.

Finding a Physician
If you do not have a primary care doctor and need guidance, you may contact the Student Services Office (215-965-4040) and we can assist you in figuring out the steps to finding a doctor's office or clinic. All charges for your office visit are your responsibility. There is typically a fee for a visit, in addition to the charge for vaccinations or laboratory work you may require. You must bring previous vaccination records to the physician as well.

We are pleased to say that the college is well equipped to meet your health needs. There are no long waits or anonymity often associated with university health services. We welcome you as an incoming student and look forward to helping you stay healthy while you pursue your education as an artist.

Sincerely,
Diane Azuma
Director of Health Services
Tel: 215-965-4032
Fax: 215-564-1459
Health History and Immunization Form Checklist

Use this form as a checklist to make sure every section of this form is completed by you and your Health Care Provider.

There are five sections of the form.

A. Section I: Health History—to be completed by the Student.

This information is strictly for the use by Health Services Staff and will not be released to anyone. **All students must sign the bottom of Section I, verifying that the information is correct.**

*Note, if you are under the age of 18, your parent or guardian must sign directly below in the section labeled “Parental Permit.”

B. Section II: List of Required vaccines and Recommended vaccines

Please read through the listed vaccines. Your doctor will be required to fill out and verify in the next section. Also discuss with your health care provider the need for the additional four vaccines indicated on the bottom of the page.

C. Section III: Immunization Record—to be completed by a physician

In addition to attaching an official copy of your immunization record, your physician must complete this section of the form. If you do not have a required vaccine, the record indicates the next steps your physician must take.

D. Section IV: Tuberculosis Screening—to be completed by you AND the Physician

Your doctor should read over this section and circle either yes or no for each bullet point. If you circle yes to any of the questions, your doctor must conduct a Tuberculin skin Test.

E. Section V: Tuberculosis Risk Assessment—to be completed by physician.

If it is determined that you must receive a TB Skin Test, as indicated in Section IV, your doctor must go through the steps of filling out this form. The results of this test take several days to read; therefore you will need to bring back this section of the form when you return to the office for the results in order for this form to be completed.

F. Additional Reminders

1. Make sure your Health Care Provider Signs and dates the form on page 7. It will not be complete until she/he does so.
2. Do not forget to attach a copy of your current insurance plan as well as a copy of your immunization record.
3. Instructions for returning the form are provided on page 7.
SECTION I: TO BE FILLED OUT BY THE STUDENT

A health history must be completed by **ALL** students. This information is strictly for the use of the Student Health Services and will not be released to anyone without your knowledge or consent. **PLEASE COMPLETE AND RETURN DIRECTLY TO THE DIRECTOR OF HEALTH SERVICES.**

<table>
<thead>
<tr>
<th>Last name</th>
<th>First</th>
<th>Middle</th>
<th>Moore Student ID number</th>
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<tr>
<th>Home address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Local address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<thead>
<tr>
<th>Date of Birth</th>
<th>Marital Status</th>
<th>Class Entering</th>
<th>Home Telephone</th>
<th>Cell phone #</th>
</tr>
</thead>
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<tr>
<th>Emergency Contact Person</th>
<th>Home Telephone</th>
<th>Business Telephone</th>
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</thead>
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**HEALTH INSURANCE INFORMATION:** PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR HEALTH INSURANCE CARDS

**PERSONAL HISTORY:** Please answer all questions

### Gastrointestinal:
- **Yes**
- **No**

- Constipation
- Recurrent diarrhea
- Hemorrhoids
- Ulcer
- Frequent upset stomach
- Heartburn
- Irritable bowel
- Jaundice
- Gall bladder problem
- Hernia
- Other:

### Skin:
- **Yes**
- **No**

- Acne
- Eczema
- Psoriasis
- Rashes
- Other:

### Head:
- **Yes**
- **No**

- Eye problems
- Glasses/Contacts
- Ear infections
- Hearing difficulty
- Nose problems
- Sinusitis
- Throat problem
- Other:

### Neurological:
- **Yes**
- **No**

- Headache
- Dizziness/fainting
- Seizures
- Weakness
- Head injury/concussion
- Paralysis
- Loss of consciousness
- Frequent anxiety
- Frequent depression
- Worry/nervousness
- Other:

### Cardiac:
- **Yes**
- **No**

- Murmur
- High or low blood pressure
- Anemia
- Antibiotics prior to dental work
- Palpitations
- Chest pain
- Blood clots
- High cholesterol
- Other:

### Respiratory:
- **Yes**
- **No**

- Asthma
- Bronchitis
- Pneumonia
- Tuberculosis
- Chronic cough
- Shortness of breath
- Other:

### Genitourinary:
- **Yes**
- **No**

- Kidney disease
- Bladder/kidney infections
- Kidney stones
- Sexually transmitted infection
- No period
- Painful periods
- Irregular periods
- Breast lump
- Pelvic infection
- Pregnancies
- Other:

### Other:
- **Yes**
- **No**

- Cancer
- Anorexia / bulimia
- Radiation/chemotherapy
- Recent weight gain/loss
- Do you drink alcohol?
- Do you smoke?

### Infectious Illnesses:
- **Yes**
- **No**

- Chicken pox
- Measles
- Rubella-German measles
- Mumps
- Mononucleosis
- Hepatitis Type
- Rheumatic fever
- Other:

### Personal Health Information

- **START DATE:**
- Undergraduate
- SADI
- Graduate
- Post Bacc.

- **SECTION I: TO BE FILLED OUT BY THE STUDENT**

- **A health history must be completed by ALL students. This information is strictly for the use of the Student Health Services and will not be released to anyone without your knowledge or consent.**

- **PLEASE COMPLETE AND RETURN DIRECTLY TO THE DIRECTOR OF HEALTH SERVICES.**

- **HEALTH INSURANCE INFORMATION:** PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR HEALTH INSURANCE CARDS

- **PERSONAL HISTORY:** Please answer all questions

- **Gastrointestinal:**
- **Skin:**
- **Head:**
- **Neurological:**
- **Cardiac:**
- **Respiratory:**
- **Genitourinary:**
- **Other:**
- **Infectious Illnesses:**

- **MOORE COLLEGE OF ART & DESIGN**

- **Inspiring Careers**

- **START DATE:**
- Undergraduate
- SADI
- Graduate
- Post Bacc.
Do you take any medications? (ie: all drugs, including over the counter drugs, birth control pills, laxatives, sleeping medications, etc.)  Yes_______  No________

If yes, please list: ______________________________________________________________________________________________________________

Please list Physician(s), Dentist, Ophthalmologist

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone number</th>
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</tr>
</tbody>
</table>

Are you allergic to any medications?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>If yes, please give details</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

Allergies (Food, insects, others)  

| ☐   | ☐  |                             |

Have you had difficulty with school studies or teachers?

| ☐   | ☐  |                             |

Have you had an illness or injury or been hospitalized other than already noted?

| ☐   | ☐  |                             |

Have you received treatment or counseling for stress, nervous condition, personality or character disorder, or emotional problem?

| ☐   | ☐  |                             |

FAMILY HISTORY

<table>
<thead>
<tr>
<th>Parents</th>
<th>Age</th>
<th>State of Health</th>
<th>Occupation</th>
<th>Age of Death</th>
<th>Cause of Death</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

TO BE SIGNED BY THE STUDENT (MUST BE SIGNED BY STUDENT OR FORM WILL NOT BE PROCESSED)

I. STUDENT STATEMENT

ALL STUDENTS: The information provided in this form is correct. I understand that failure to complete the form correctly may jeopardize my student standing at Moore College of Art & Design. I will return the form to the appropriate address at the end of this form.

Student Signature_____________________________________________________ Student ID #: ________________________________

Signature of parent/guardian if student is a minor____________________ _______________________________ Date____________

PARENTAL PERMIT

The Law requires that parental permission be obtained for procedures on minors. The following consent form should be signed by the parents so that such procedures may be promptly carried out with no unnecessary delays. However, no major operation will be performed, except in extreme emergency, without parents being contacted and fully informed. I give permission for such diagnostic and therapeutic procedure as may be deemed necessary for my daughter and also to present information concerning her medical condition to other responsible college officials when deemed desirable.

Signature_____________________________________________________ Relationship____________________ Date____________
SECTION II: List of Immunization Requirements

As a condition of enrollment, all full-time students and all students living in campus housing must meet the following requirements. Failure to meet these requirements will result in denial of student registration privileges.

1. **Hepatitis B**
   - 3 doses of Hepatitis B vaccine are required. Doses 1 and 2 must be administered at least 4 weeks apart. Dose 3 should be at least 6 months after the 1st dose and 8 weeks after the 2nd dose. OR
   - Blood test showing immunity

2. **Measles, Mumps, Rubella (MMR)**
   - 2 doses of MMR vaccine are required. Dose 1 must be administered after the 1st birthday. Dose 2 must be administered at least 4 weeks after the 1st dose. OR
   - Blood test showing immunity

3. **Varicella (Chicken Pox)**
   - 2 doses of varicella (chicken pox) vaccine are required. They must be administered at least 4 weeks apart. OR
   - Blood test showing immunity OR
   - Physician documented history of chicken pox disease

4. **Tetanus-Diphtheria-Pertussis (Tdap)**
   - 1 dose of Tdap (tetanus toxoid, reduced diphtheria toxoid and acellular pertussis) vaccine is required, and must be dated 2005 or later.
   - Td (tetanus-diptheria) vaccine does not satisfy this requirement.
   - Td vaccine booster is also required if Tdap is older than 10 years.

5. **Meningococcal**
   - 1 dose of meningococcal conjugate vaccine (MCV4, such as Menactra or Menveo) administered since age 16 is required of all incoming students who are age 21 or younger.
     - Meningococcal conjugate vaccine is preferred although meningococcal polysaccharide vaccine (MPSV4, such as Menomune) is acceptable.
     - At minimum, serogroups A, C, Y, and W-135 must be covered.
   - Incoming students living on campus who are age 22 or older may submit either proof of vaccination or a Meningococcal Vaccine Waiver.
   - [www.cdc.gov/meningococcal](http://www.cdc.gov/meningococcal)

6. **Tuberculosis**
   - Screening and risk assessment required. Please discuss with healthcare provider.

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Please discuss the need for the following vaccines with your healthcare provider.

7. **Influenza**
   - Trivalent inactivated influenza vaccine (TIV) ____ Live attenuated influenza vaccine (LAIV) ____

8. **Quadrivalent Human Papillomavirus Vaccine (HPV2, HPV4 or HPV9)**
   - (Three doses of vaccine for females and male 11-26 years of age at 0, 2, and 6 month intervals.)

9. **Pneumococcal Polysaccharide Vaccine**
   - (One dose for members of high-risk groups)

10. **Meningococcal Serogroup B**
    - (Two or three dose series; may be given to any college student or for outbreak control; may be given with quadrivalent meningococcal vaccine at different anatomic site. Must complete series with the same vaccine.)
## SECTION III: IMMUNIZATION RECORD

**PART 1: COMPLETED BY THE STUDENT.**  
ALL INFORMATION MUST BE PRINTED LEGIBLY OR FORM CANNOT BE PROCESSED.

Last Name: __________________________________   First Name:  __________________________________________ Middle Initial: ___________

DOB: _____ / ______ / ______        Date of Entry: _____ / ______ / ______            Student ID #:  ___  ___  ___  ___   ___  ___  ___  ___  ___

Full Mailing Address:
Street Address ___________________________________________  City ______________________ State  _______  ZIP Code ________________

Please Check:  ___ Resident Please Check:  ___ Undergraduate   ___ SADI  
___ Commuter   ___ Graduate ___ Post Bacc.

**PART 2: TO BE COMPLETED AND SIGNED BY YOUR HEALTHCARE PROVIDER.**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dose 1</th>
<th>Dose 2</th>
<th>Dose 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td><em><strong>/</strong>/</em>__</td>
<td><em><strong>/</strong>/</em>__</td>
<td><em><strong>/</strong>/</em>__</td>
</tr>
<tr>
<td>Hepatitis B Surface Antibody</td>
<td>Month Day Year</td>
<td>Month Day Year</td>
<td>Month Day Year</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella</td>
<td>MMR Dose 1</td>
<td>Measles Dose 1</td>
<td>Mumps Dose 1</td>
</tr>
<tr>
<td>Measles Antibody</td>
<td>month_____ yr.____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps Antibody</td>
<td>month_____ yr.____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella Antibody</td>
<td>month_____ yr.____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal (serogroups A, C, Y, and W-135)</td>
<td>Last Dose</td>
<td>Meningococcal Last Dose</td>
<td>Please specify vaccine type:</td>
</tr>
<tr>
<td>Tetanus-Diphtheria and Pertussis (Tdap)</td>
<td>Tdap</td>
<td>Td</td>
<td>or Serogroups covered:</td>
</tr>
<tr>
<td>Varicella (Chicken Pox)</td>
<td>Dose 1</td>
<td>Dose 2</td>
<td>Varicella Illness</td>
</tr>
<tr>
<td>Varicella antibody</td>
<td>month_____ yr.____</td>
<td>result: positive_______negative_______</td>
<td>month_____ yr.____</td>
</tr>
</tbody>
</table>

Other: 

THIS FORM IS DUE AUGUST 1, 2016 (Incoming Residents)  
THIS FORM IS DUE SEPTEMBER 12, 2016 (Commuter Students)
Section IV: To be completed by Student and Physician.

Last Name ____________________________________ First Name ____________________ DOB __________________

TUBERCULOSIS (TB) SCREENING/TESTING

Please answer the following questions:

1. Have you ever had close contact with persons known or suspected to have active TB disease? ☐ Yes ☐ No

2. Were you born in one of the countries listed below that have a high incidence of active TB disease? ☐ Yes ☐ No

(If yes, please CIRCLE the country, below)

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Côte d’Ivoire
Democratic People’s Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran (Islamic Republic of)
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People’s Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldive
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Somalia South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Tajikistan
Thailand
Timor-Leste
Togo
Trinidad and Tobago
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe


3. Have you had frequent or prolonged visits* to one or more of the countries listed above with a high prevalence of TB disease? ☐ Yes ☐ No

(If yes, CHECK the countries, above)

4. Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ☐ Yes ☐ No

5. Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? ☐ Yes ☐ No

6. Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease. – medically underserved, low-income, or abusing drugs or alcohol? ☐ Yes ☐ No

If the answer is YES to any of the above questions, Moore College of Art & Design requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester.

If the answer to all of the above questions is NO, no further testing required.

*The significance of the travel exposure should be discussed with a health care provider and evaluated.
TUBERCULOSIS (TB) RISK ASSESSMENT (to be completed by health care provider). Clinicians should review and verify the information above.

Persons answering YES to any of the questions in Section IV are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below)

- Yes
- No

History of BCG vaccination? (If yes, consider IGRA if possible.)

- Yes
- No

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
- Unexplained weight loss
- Night sweats
- Fever

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: __/__/__
- Result: ________ mm of induration  **Interpretation: positive____ negative____

- Date Given: __/__/__  Date Read: __/__/__
- Result: ________ mm of induration  **Interpretation: positive____ negative____

**Interpretation guidelines

An induration of 5 or more millimeters is positive:

- Recent close contacts of an individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- Organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 mo.)
- HIV-infected persons

An induration of 10 or more millimeters is positive:

- Recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
- Injection drug users
- Mycobacteriology laboratory personnel
- Residents, employees, or volunteers in high-risk congregate settings
- Persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

An induration of 15 or more millimeters is positive:

- Persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

3. Interferon Gamma Release Assay (IGRA)

- Date Obtained: __/__/__ (specify method)  QFT-GIT  T-Spot  other____
  - Result: negative____ positive____ indeterminate____ borderline____ (T-Spot only)

- Date Obtained: __/__/__ (specify method)  QFT-GIT  T-Spot other____
  - Result: negative____ positive____ indeterminate____ borderline____ (T-Spot only)

4. Chest x-ray: (Required if TST or IGRA is positive)

- Date of chest x-ray: __/__/__  Result: normal____ abnormal____
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 fibrotic changes on chest radiograph consistent with prior TB disease
- Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- Have had a gastrectomy or jejunooileal bypass
- Weigh less than 90% of their ideal body weight
- Cigarette smokers and persons who abuse drugs and/or alcohol
- Populations defined locally as having an increased incidence of disease due to M. tuberculosis, including medically underserved, low-income populations

☐ Student agrees to receive treatment
☐ Student declines treatment at this time

HEALTH CARE PROVIDER (Signature Required)

Please provide this completed form and a copy of all original immunization records, including any immunization blood tests showing immunity.

I have verified that the individual I have examined is the named individual on this form and that the above tests/vaccinations were performed in this office/laboratory, or I have reviewed any documentation relative to the students immunization record.

Provider Name:

Address:

Phone:

Signature of Healthcare Provider:  
Date:

Please return completed forms to: Moore College of Art & Design Health Services Office 20th Street and The Parkway Philadelphia, PA 19103 215.965.4032 215.564.1459 (fax) healthservices@moore.edu