From the Health Services Office

Welcome to Moore College of Art & Design. I am Diane Azuma, the Director of Health Services. My hours are 9 a.m. - 3 p.m. Monday through Friday to meet students' routine health care needs and to handle emergencies. Health Services is located on the first floor of Stahl Hall.

In addition, the College refers students to an area PENN CARE physician practice. The PENN CARE practice is an internal medicine practice affiliated with University of Pennsylvania Health System. Office visits and diagnostic tests are billed to the students’ insurance. We are usually able to get students prompt appointments. If a student needs a specialist, I can also handle some referrals. In addition to this coverage for your physical needs, we have in Student Services a wonderful College Counselor, Ruth Gayle, M.Ed., who has been working with artists here at Moore for over 15 years and who is well respected by students, faculty and staff.

The College requires that students have health insurance. Many of our students are already insured under their family’s health insurance plan. Those students will need to submit documentation of coverage. All others must purchase the school’s health insurance. Further details can be found in the following section.

I am enclosing a health form; it is the student's responsibility to have this form completed, signed by their physician, and returned to the Health Services Office. This form is kept in a confidential file in Health Services so that I can better serve your needs.

The health form, including a copy front and back of your health insurance card and immunization record signed by your physician, must be completed and returned to the school by August 1, 2012. A completed health form is required for both commuters and residents. Residents without completed health forms may not move into housing. To assist in making your transition to college smoother, we have some suggestions for you. Plan ahead! At this time of the year, it is difficult to get a timely appointment with your physician due to the increased demand of students needing physicals for school. Secondly, know what your health insurance is, have the card with you, and find out how to use it. Thirdly, if you are being treated for any long term medical or psychological conditions and you will be far away from home, we suggest that you discuss with your physician and/or therapist about making connections to physicians or therapists near school to ensure continuity of care while you are at school.

If you do not have a physician to complete this form, you may make an appointment by calling PENN CARE @ Rittenhouse at 215-893-6200 to complete this form. You should make this appointment prior to the deadline for return of the health form. There is a fee for this visit in addition to the charge for vaccinations or laboratory work you may require. You must bring previous vaccination records. All charges for this appointment are the responsibility of the student.

Because the College must have your health form to properly address your medical needs, failure to return a completed health form by September 6, 2012 will result in a $100 penalty, and a hold will be placed on your student account.

I am 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. I welcome you as an incoming student, and I look forward to helping you stay healthy while you pursue your education as an artist.

Diane Azuma, R.N.
Director of Health Services
Stahl Hall First Floor
Telephone # 215-965-4032
Fax # 215-564-1459
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>Social Security Number</th>
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</thead>
<tbody>
<tr>
<td>Home address</td>
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<tr>
<td>Local address</td>
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<tr>
<td>Cell phone #</td>
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<tr>
<td>Date of Birth</td>
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<td></td>
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<tr>
<td>Next of Kin’s name (relationship)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>HEATH INSURANCE INFORMATION:</td>
<td></td>
<td></td>
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<tr>
<td>HEALTH INSURANCE INFORMATION: PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR HEALTH INSURANCE CARDS</td>
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**PERSONAL HISTORY:** Please answer all questions

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<td>Constipation</td>
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<td></td>
</tr>
<tr>
<td>Recurrent diarrhea</td>
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</tr>
<tr>
<td>Hemorrhoids</td>
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</tr>
<tr>
<td>Ulcer</td>
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<tr>
<td>Frequent upset stomach</td>
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<tr>
<td>Heartburn</td>
<td></td>
<td></td>
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<tr>
<td>Irritable bowel</td>
<td></td>
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<tr>
<td>Jaundice</td>
<td></td>
<td></td>
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<tr>
<td>Gall bladder problem</td>
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<tr>
<td>Hernia</td>
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<td>Other:</td>
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<tr>
<td>Bladder/kidney infections</td>
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<td>Kidney stones</td>
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<tr>
<td>Sexually transmitted infection</td>
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<tr>
<td>No period</td>
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<tr>
<td>Painful periods</td>
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<td>Irregular periods</td>
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<td>Breast lump</td>
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<td>Pelvic infection</td>
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<tr>
<td>Pregnancies</td>
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<td>Other:</td>
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<th>Musculoskeletal:</th>
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<tr>
<td>Back problems</td>
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<tr>
<td>Arthritis</td>
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<td></td>
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<tr>
<td>Strains/sprains</td>
<td></td>
<td></td>
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<tr>
<td>Neck injury</td>
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<td></td>
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<tr>
<td>Other:</td>
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<table>
<thead>
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<th>Skin:</th>
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<tbody>
<tr>
<td>Acne</td>
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<tr>
<td>Eczema</td>
<td></td>
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<tr>
<td>Psoriasis</td>
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<td></td>
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<tr>
<td>Rashes</td>
<td></td>
<td></td>
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<tr>
<td>Other:</td>
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<table>
<thead>
<tr>
<th>Head:</th>
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<tr>
<td>Eye problems</td>
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<td></td>
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<tr>
<td>Glasses/Contacts</td>
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<tr>
<td>Ear infections</td>
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<tr>
<td>Hearing difficulty</td>
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<tr>
<td>Nose problems</td>
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<tr>
<td>Sinusitis</td>
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<td></td>
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<tr>
<td>Throat problem</td>
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<tr>
<td>Other:</td>
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<table>
<thead>
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<tbody>
<tr>
<td>Murmur</td>
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<td></td>
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<tr>
<td>High or low blood pressure</td>
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<table>
<thead>
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<th>Respiratory:</th>
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</thead>
<tbody>
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<td>Asthma</td>
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<tr>
<td>Bronchitis</td>
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<tr>
<td>Pneumonia</td>
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<tr>
<td>Tuberculosis</td>
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<td></td>
</tr>
<tr>
<td>Chronic cough</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath</td>
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<td></td>
</tr>
<tr>
<td>Other:</td>
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<table>
<thead>
<tr>
<th>Neurological:</th>
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<th>No</th>
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<tbody>
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<td>Headache</td>
<td></td>
<td></td>
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<tr>
<td>Dizziness/fainting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures</td>
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<td></td>
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<tr>
<td>Weakness</td>
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<td></td>
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<tr>
<td>Head injury/concussion</td>
<td></td>
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</tr>
<tr>
<td>Paralysis</td>
<td></td>
<td></td>
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<tr>
<td>Loss of consciousness</td>
<td></td>
<td></td>
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<tr>
<td>Frequent anxiety</td>
<td></td>
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</tr>
</tbody>
</table>
### Metabolic/Endocrine:
- **Diabetes**
- **Thyroid disorder**
- **Other:**

### Infectious Illnesses:
- **Chicken pox**
- **Measles**
- **Rubella-German measles**

---

**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**

---

**Telephone number**

---

---

**Are you allergic to any medications?**
- Yes ______ No _______

**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>
</table>

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**Number of brothers_______ sisters_______**

### HAVE ANY OF YOUR BLOOD RELATIVES EVER HAD ANY OF THE FOLLOWING?**

<table>
<thead>
<tr>
<th>Tuberculosis</th>
<th>Yes</th>
<th>No</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Yes</td>
<td>No</td>
<td>Relationship</td>
</tr>
<tr>
<td>Kidney disease</td>
<td>Yes</td>
<td>No</td>
<td>Relationship</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Yes</td>
<td>No</td>
<td>Relationship</td>
</tr>
<tr>
<td>Stomach disease</td>
<td>Yes</td>
<td>No</td>
<td>Relationship</td>
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<tr>
<td>Asthma</td>
<td>Yes</td>
<td>No</td>
<td>Relationship</td>
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<tr>
<td>Bleeding disorder</td>
<td>Yes</td>
<td>No</td>
<td>Relationship</td>
</tr>
<tr>
<td>Hay fever</td>
<td>Yes</td>
<td>No</td>
<td>Relationship</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>Yes</td>
<td>No</td>
<td>Relationship</td>
</tr>
<tr>
<td>Convulsions</td>
<td>Yes</td>
<td>No</td>
<td>Relationship</td>
</tr>
<tr>
<td>Cancer</td>
<td>Yes</td>
<td>No</td>
<td>Relationship</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>Yes</td>
<td>No</td>
<td>Relationship</td>
</tr>
<tr>
<td>Stroke</td>
<td>Yes</td>
<td>No</td>
<td>Relationship</td>
</tr>
<tr>
<td>Suicide</td>
<td>Yes</td>
<td>No</td>
<td>Relationship</td>
</tr>
</tbody>
</table>

---

**The information on this form is accurate and complete to the best of my knowledge.**

Signature __________________________ Date ____________
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 ____________
# Immunization Record

## Part I

**Name**  
Last Name: ___________________________  
First Name: ___________________________

**Address**  
Street: ___________________________  
City: ___________________________  
State: ___________________________  
Zip: ___________________________

**Date of Entry** ___ /___  
**Date of Birth** ___ /___ /___  
**School ID#** ________________

Mo  
Yr  

**Part-time** ____  
**Full-time** ____  
**Undergraduate** ____  
**Post-bacc** ____  
**Commuter** ____  
**Resident** ____

## Part II – TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.  All information must be in English.

### A. M.M.R. (Measles, Mumps, Rubella) (Two doses required at least 28 days apart for students born after 1956.)

1. Dose 1 given at age 12 months or later............................................................................................................................ #1___/___

2. Dose 2 given at least 28 days after first dose ............................................................................................................................ #2 ___/___

### B. Polio (Primary series, doses at least 28 days apart. Three primary series are acceptable. Refer to ACIP website for details.)

1. OPV alone (oral Sabin three doses): ………………#1___/___ #2___/___ #3___/___

2. IPV/OPV sequential: ………………………IPV #1___/___ IPV #2___/___ OPV #3___/___ OPV #4___/___

3. IPV alone (injected Salk four doses): …………#1___/___ #2___/___ #3___/___ #4 ___/___

### C. Varicella (Birth in the US before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement)

1. History of Disease  
   Yes _______  
   No_________  
   or Birth is US before 1980  
   Yes _______ No_________

2. Varicella antibody /__  
   Result: Reactive_______  
   Non – reactive________

3. Immunization  
   a. Dose #1 ............................................................................................................................ #1___/___

   b. Dose #2, given at least 12 weeks after first dose 1-12 years and at least 4 weeks after the first dose if age 13 years or older…………………….……#1 ___/___

### D. Tetanus-Diphtheria-Pertussis

1. Primary series completed?  
   Yes _____  
   No_______

   Date of last dose in series: _____/___ /____

2. Date of most recent booster dose: _____/___ /____

   Type of Booster:  
   Td _____  
   Tdap _____

   Tdap Booster recommended for ages 11-64 unless contraindicated.
Immunization Record

Last Name ___________________________ First Name ______________________ DOB ________________

E. Hepatitis A

1. Immunization (Hepatitis A)
   a. Dose #1 _____/_____/____  
   b. Dose #2 _____/_____/____ 
   M            D      Y                               M         D       Y

2. Immunization (Combined Hepatitis A and B Vaccine) 
   a. Dose #1 _____/_____ /_____  
   b. Dose #2 _____/_____/____  
   c. Dose #3 _____/_____/____ 
   M          D            Y               M           D            Y              M           D            Y

F. Hepatitis B (ALL COLLEGE STUDENTS- Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or a positive Hepatitis B surface antibody meets the requirement.)

1. Immunization (Hepatitis B)
   a. Dose #1 _____/_____/____   
   b. Dose #2 _____/_____/____  
   c. Dose #3 _____/_____/____  
   M          D            Y            M          D            Y             M          D            Y

   Adult form ___ Child form ___   Adult form ___ Child form ___   Adult form ___ Child form ___

2. Immunization (Combined Hepatitis A and B Vaccine)
   a. Dose #1 _____/_____ /_____  
   b. Dose #2 _____/_____/____  
   c. Dose #3 _____/_____/____  
   M          D            Y                M          D            Y                M          D            Y

3. Hepatitis B surface antibody Date  _____/_____  Result: Reactive _____  Non-reactive _____

G. Meningococcal Quadrivalent (A, C, Y, W-135) One or Two doses for all college students – revaccinate every 5 years if increased risk continues.

   Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible):
   Dose # 1 _____/_____/_____     Dose #2 _____/_____/_____     
   M             D         Y                 M             D         Y

   Tetravalent polysaccharide (acceptable alternative if conjugate not Available; 
   Date  _____/_____/_____     Date  _____/_____/_____  
   M          D            Y                      M          D            Y

H. Pneumococcal Polysaccharide Vaccine (One dose for members of high-risk groups) Date: ____/____/____

I. Influenza
   Date of last dose: ____/____/____
   Trivalent inactivated influenza vaccine (TIV) _____ Live attenuated influenza vaccine (LAIV) _____

J. Quadrivalent Human Papillomavirus Vaccine (HPV2 or HPV4)
   (Three doses of vaccine for females and males11-26 years of age at 0, 2, and 6 month intervals.)

   Immunization (HPV)
   a. Dose #1 _____/_____   
   b. Dose #2 _____/_____  
   c. Dose #3 _____/_____  
   Mo         Yr                 Mo         Yr                         Mo         Yr
K. TUBERCULOSIS (TB) SCREENING/TESTING1

Please answer the following questions:

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

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  Dominican Republic  Ethiopia  Malawi  Seychelles
Algeria  Ecuador  El Salvador  Malaysia  Sierra Leone
Angola  Maldives  Somalia
Argentina  Equatorial Guinea  Mauritania  Solomon Islands
Armenia  Mali  South Africa
Azerbaijan  Marshall Islands  Mauritius  Sri Lanka
Bangladesh  Fiji  Micronesia (Federated States of)  Sudan
Belarus  Gabon  Mongolia  Suriname
Belize  Gambia  Morocco  Swaziland
Benin  Georgia  Mozambique  Syrian Arab Republic
Bhutan  Ghana  Myanmar  Tajikistan
Bolivia (Plurinational State of)  Guam  Namibia  Thailand
Bosnia and Herzegovina  Guatemala  Nepal  The former Yugoslav Republic of Macedonia
Botswana  Guinea  Nicaragua  Togo
Brazil  Guinea-Bissau  Niger  Timor-Leste
Brunei Darussalam  Guyana  Nigeria  Togo
Bulgaria  Haiti  Pakistan  Tunisia
Burkina Faso  Honduras  Palau  Turkey
Burundi  India  Panama  Turkmenistan
Cambodia  Indonesia  Papua New Guinea  Tuvalu
Cameroon  Iraq  Paraguay  Uganda
Cape Verde  Japan  Peru  Ukraine
Central African Republic  Kazakhstan  Philippines  United Republic of
Chad  Kenya  Poland  Tanzania
China  Kiribati  Portugal  Uruguay
Colombia  Kuwait  Qatar  Uzbekistan
Comoros  Kyrgyzstan  Republic of Korea  Vanuatu
Congo  Lao People's Democratic Republic  Republic of Moldova  Venezuela (Bolivarian Republic of)
Côte d'Ivoire  Latvia  Russian Federation  Viet Nam
Croatia  Lesotho  Rwanda  Yemen
Democratic People's Republic of Korea  Liberia  Saint Vincent and the Grenadines  Zimbabwe
Democratic Republic of the Congo  Libyan Arab Jamahiriya  Sao Tome and Principe
Djibouti  Madagascar  Senegal

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2010. Countries with incidence rates of >20 cases per 100,000 population. For future updates, refer to [http://apps.who.int/ghodata](http://apps.who.int/ghodata)

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)

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

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

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 or further action is required.

* The significance of the travel exposure should be discussed with a health care provider and evaluated.
Immunization Record

Last Name ______________________________ First Name ______________________ DOB ________________

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 Part K 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: ____/____/____

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____

**Interpretation guidelines

>5 mm 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

>10 mm 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.

>15 mm 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.

*The significance of the travel exposure should be discussed with a health care provider and evaluated.

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/____/____ (specify method)  QFT-GIT  T-Spot  other_____

M       D       Y

Result: negative___  positive___  indeterminate___  borderline___ (T-Spot only)

Date Obtained: ____/____/____ (specify method)  QFT-GIT  T-Spot other_____

M       D       Y

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____

M      D       Y

Fall 2012.doc
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 jejunoileal 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

Please circle:

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

__________________________

HEALTH CARE PROVIDER

Name __________________________________________

Address _________________________________________

Phone __________________________________________

Physician's Signature _____________________________

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)
Important Health Information
For Resident Students

PENNSYLVANIA STATE LAW REQUIRES ALL STUDENTS IN SCHOOL HOUSING TO BE IMMUNIZED AGAINST MENINGOCOCCAL DISEASE.

The U.S. Centers for Disease Control and Prevention’s (CDC) Advisory Committee on Immunization Practices (ACIP) and the American College Health Association (ACHA) urge all first-year students living in residence halls to be immunized against meningococcal disease.

The ACIP and ACHA recommendations further state that other college students under 25 years of age who wish to reduce their risk for the disease may choose to be vaccinated.

Meningococcal disease strikes 1,400 to 3,000 Americans each year and is responsible for approximately 150 to 300 deaths. Adolescents and young adults account for nearly 30 percent of all cases of meningitis in the United States. In addition, approximately 100-125 cases of meningococcal disease occur on college campuses each year, and five to 15 students will die as a result.

Due to lifestyle factors, such as crowded living situations, bar patronage, active or passive smoking, irregular sleep patterns, and sharing of personal items, college students living in residence halls are more likely to acquire meningococcal disease than the general college population.

Meningococcal infection is contagious, and progresses very rapidly. It can easily be misdiagnosed as the flu, and, if not treated early, meningitis can lead to death or permanent disabilities. One in five of those who survive will suffer from long-term side effects, such as brain damage, hearing loss, seizures, or limb amputation.

For more information, please feel free to contact our health service and/or consult your child’s physician. You also can find information about the disease and immunization by visiting the ACHA website, www.acha.org/meningitis, and the CDC website, http://www.cdc.gov/meningitis

A student, age 18 or older, may be excused from the vaccination for religious reasons or ethical reasons, provided she signs the attached waiver requesting exemption. A student, under the age of 18, may be excused from the meningococcal vaccination only if the student’s parent/guardian signs a written waiver for school records.

Therefore, before you can be admitted to student housing you must provide the college with (1) proof of vaccination given at age 16 years or older or (2) an exemption form signed by you or your parent/guardian (if you are under the age of 18) waiving the vaccination.

MOORE encourages all students to be properly vaccinated.
Meningococcal Vaccine Exemption Form

I. For students 18 years of age or older

I, _________________________ (student name) choose to be exempt from the meningococcal disease vaccine requirement set forth by Pennsylvania State Law, for religious or other reasons.

I have received and understand the information provided by Moore College of Art and Design on the risks of associated with meningococcal disease and the availability and effectiveness of the vaccine. I have also discussed this decision with my physician and parent/guardian before signing this form.

__________________________________ ________________ _____________
Student signature    Date   Age

II. For parents/guardians of students under the age of 18

I, __________________________, parent/guardian of ___________________________ acknowledge  
that I have received the information, provided to my daughter by Moore College of Art & Design, concerning the risks associated with meningococcal disease and the availability and the effectiveness of the vaccine. I have also discussed this information with my daughter and her physician. I have chosen not to have my daughter vaccinated against meningococcal disease for religious or other reasons. By signing below, I represent that I have the right to make medical decisions on behalf of my daughter.

____________________________________________
Print name of Parent/Guardian

____________________________________________
Parent/Guardian signature

_________________________
Date