HAMPSHIRE COLLEGE HEALTH & COUNSELING SERVICES

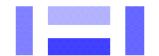
893 West Street, Amherst, MA 01002

PH (413) 559.5458 FX (413) 559.5583 healthservices@hampshire.edu

IMMUNIZATION FORM

THIS FORM IS REQUIRED · STUDENT COMPLETES · DUE JULY 1 FOR FALL AND JANUARY 15 FOR SPRING

This form should be completed by a healthcare provider who is not a fam spring se		y 1 for the fall seme	ester and January 15 for the		
Legal Name: First		Date of Birth:			
	Middle Initial	m	onth day year		
Chosen Name(if different):					
REQUIRED IMMUNIZATIONS (to be completed b	y a healthcare prov	ider)			
The following immunizations are required by Massachusetts Law. All date available or if a blood test indicates that you are NOT immune, you must be		/year. If documenta	tion of immunization is not		
TETANUS-DIPTHERIA-PERTUSSIS One dose of Tdap is required within the last 10 years.		I.M.R. (Measles, Mumps, Rubella) (two doses required, at least ne month apart, after 12 months of age)			
	Dose 1://	_/ Dose	2: / day /year		
Tdap Date:///			(lab report must be included)		
MENINGOCOCCAL	HEPATITIS B (three d	loses required)			
(last dose within last 5 years)	Dose 1: / /	/			
MCV4(Menactra or Menveo)	Dose 1: / day Dose 2: / day (MUST BE AT LEA	/			
OR mo day year					
Menomune / / / mo. day year	Dose 3: / day (MUST BE AT LEA	/ year .st two months after	R #2 AND FOUR MONTHS AFTER #1)		
Waiver available on website: www.hampshire.edu/health-services/	OR Positive Hbs Ab titer	,			
health-forms-for-new-students	OR Positive HbsAb titer (lab report must be include	ed) <u>mo. / day</u>	/ 		
VARICELLA (2 doses required for college first year students unless A reliable history includes a diagnosis of chickenpox, or interpretation of practitioner, physician assistant or designee; or 2) laboratory proof of imm health science students. Dose 1: / Dose 2: /	parent/guardian description nunity. Birth before 1980 in	on of chickenpox, by U.S. is acceptable fo	a physician, nurse or college students, except		
Dose 1: /day /year Dose 2: /day OR Lab test proving immunity (attach lab reports) Immun	year	Date:	/		
OR History of Disease Date:	e-fiter value	mo.	day year		
OR History of Disease, Date:///					
STRONGLY RECOMMENDED IMMUNIZATIONS	6 (to be completed	by a healthcar	e provider)		
HEPATITIS A (two doses at least 6 months apart)	HUMAN PAPILLOMA	A VIRUS (HPV)			
Dose 1: / _day / _year Dose 2: / _day / _year	Vaccine (at 0,2, and 6 mo	nth intervals)	MENINGITIS B		
PNEUMOCOCCAL VACCINE	□ Gardasil □ C	ther			
The CDC recommends vaccination for adults who have health	Dose 1: /		Dose 1://		
conditions including asthma, diabetes and other chronic problems; those with compromised immune systems and smokers.	Dose 2: /	/	Dose 2://year		
Pneumovax:mo/ _day/vear	Dose 3: / day	/	, ,		
mo. day year	11101 414)	yeur			
HEALTHCARE PROVIDER SIGNATURE REQUIRED					
NAME (PRINT):		DATE: _			
ADDRESS:					
PHONE: FAX:					



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TUBERCULOSIS SCREENING

THIS FORM IS REQUIRED \cdot STUDENT COMPLETES \cdot DUE JULY 1 FOR FALL AND JANUARY 15 FOR SPRING

Name: L	ast First	Middle Initial	Date of Birth		
SECTION I: R	EQUIRED TUBERCULOSIS (TB) RISK QUEST	IONNAIRE			
1. Have you	ever been treated for active TB?			Yes	□ No
If yes, giv	e dates of treatment	From:	//	to	_//
-	ever had a positive TB skin or blood test?			Yes	□ No
If yes, wh	en?	From:	//	to	_//
•	ever been treated for latent TB?			Yes	□ No
If yes, giv	e dates of treatment	From:	//	to	_//
Were you	oorn in one of the countries listed on page 3?			Yes	□ No
, ,	ase specify				
If yes, wh	en did you come to the U.S.?/				
. Have you	traveled for more than a month in a country with a h	igh rate of TB, as liste	d on page 3? □	Yes	□ No
. To the best	of your knowledge, have you ever had close contact	with anyone sick wit	h TB? □	Yes	□ No
Have you	even been vaccinated with BCG? IF YOU ANSWERED "NO" TO ALL OF?			Yes	□ No
FCTION II.	MEDICAL EVALUATION OF COLLEGE AND U	INIVERSITY STUD	ENTS FOR LAT	FNT TURE	RCIII OSIS
	ALL TUBERCULIN SKIN TESTING MUST BE I				
A. TUBERCU	LIN SKIN TEST* (within 6 months prior to entrance)	Ι	DATE ADMINIST	ERED	
	-72 hours) mm o				
	(If no induration, mark "0.") FU Mantoux test (Intermediate PPD) only; result of multiple puncture			nd If unamailabl	a nlagga dafar
testing until y	iou arrive at Hampshire College.	e tesis, such as Tine, Heag, or	1 <i>v</i> 10 <i>n</i> 0-0 <i>u</i> cc, noi uccepu	ги. 15 иниошнион	e pieuse uejei
Risk-base	d interpretation (see reverse side)	e \square Positive	If positive, p	lease comp	lete Section III
. Interferon	Gamma Release Assay (IGRA)				
			FT-G □ QFT-G	IT other	
	☐ Negative ☐ Positive ☐ Interm	nediate			
	CHEST X-RAY AND TREATMENT	\			
	uired** (within 12 months if PPD or IGRA is positive)				
☐ Negative	☐ Positive Date		ne)		
Teaument (requ □ No	Yes Yes	tabercarosis infection	<i>)</i>		
_ INU		DRUG, DOSE, FREQUE	NCY, AND DATES		
**If PPD or I	GRA has been positive in the past but student was not treated for active	or latent TB, a chest x-ray i	s required within 12 mo	nths prior to en	rollment.
IEAI EUC.	E PROVIDER GLONATURE REQUIRE				
	E PROVIDER SIGNATURE REQUIRED		D 47	rc.	
MIXI) DIVIA	Γ):		DA	ГЕ:	
ADDRESS:					

THE 30 TB HIGH-BURDEN COUNTRIES

Top 20 by estimated absolute number (in

alphabetical order)

Angola

Bangladesh

Brazil

China

DPR Korea

Dr Congo

Ethiopia

India

Indonesia

Kenya

Mozambique

Myanmar

Nigeria

Pakistan

Philippines

Russian Federation

South Africa

Thailand

UR Tanzania

VietNam

Addition 110 by estimated incidence rate (in

alphabetical order)

Cambodia

Central African Republic

Congo

Lesotho

Liberia

Namibia

Papua New Guinea

Sierra Leone

Zambia

Zimbabwe