STUDENT AFFAIRS
SCHIFFERT HEALTH CENTER
VIRGINIA TECH

Congratulations
on your acceptance!

We at Schiffert Health Center look forward to serving your health needs to ensure your academic success. To help us do so, we need information about your health status.

Immunization History Form

Fall Entry Deadline: June 30
Spring Entry Deadline: December 31

You and your health care provider must complete and sign the Immunization History form. Submit your form by uploading a digital version to: healthyhokies.healthcenter.vt.edu Forms may also be mailed or faxed if needed.

Consent for Treatment of Minors

To be completed by parents or legal guardians of students who will be under the age of 18 when arriving on campus.

Health History

Complete the online Health History section at https://healthyhokies.healthcenter.vt.edu

Exemptions to Immunizations

On occasion, a student may elect to opt out of vaccination requirements based on religious beliefs or medical reasons (TB testing is still required). Please visit Incoming Students for forms and directions for completion.

Resources

Scheduling Visits: You can call (540) 231-6444 or visit the Student Health Portal if you'd like to schedule an appointment. To learn more about the services and resources we offer, visit www.healthcenter.vt.edu

Allergy & Immunization Clinic:
Our Allergy and Immunization Clinic can continue allergy immunotherapy injections ordered by your current allergist while you are at VT. To learn more visit https://healthcenter.vt.edu/ourservices/allergy_immunization_clinic.html

Please ensure that you have completed all required sections. You may log into the Healthy Hokies Portal to verify receipt of your form (please allow 5 business days). You will be notified of any incomplete requirements by secure message.

Contact Information

895 Washington Street, SW
Blacksburg, VA, 24061
Phone: 540-231-6444
Fax: 540-231 6900 or 540-231-7473
email: health@vt.edu
www.healthcenter.vt.edu

STUDENT AFFAIRS
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VIRGINIA TECH

Immunization History Form: Part I

[TO BE COMPLETED BY INCOMING STUDENT OR PARENT/LEGAL GUARDIAN]

Due dates for students: June 30 (Fall start) and December 31 (Spring Start).
Students who have not submitted forms by the due date are subject to a $100 late fee.

Student Name _____
Last First Middle

Date of Birth: ____/____/_____ University ID# _____ State or Country of Birth: _____

Address: _____
Street City State Zip

Term Entering: ☐ Fall ☐ Spring

Student Cell Phone _____-_____-_____ Student Alternate Phone Number _____-_____-_____ (☐ home ☐ work)

Emergency Contact: (Parent/Guardian/Spouse/Next-of-Kin)

Name: _____ Relationship to Student: _____
Last First

Address: _____
Street City State Zip Country

Phone Number: _____-_____-_____ Work or Cell Phone: _____-_____-_____

CONSENT FOR THE TREATMENT OF MINORS

To be completed by parents or legal guardians of students who will be under 18 years of age when arriving on campus.

The Virginia Tech Schiffert Health Center has my permission to treat my minor child in the event of a medical emergency. Virginia Tech Schiffert Health Center also has my permission to treat my child for routine medical care, including check-ups, immunizations, and/or treatment for minor injuries and illnesses.

Parent/Guardian Signature: _____ **Date:** _____/_____/_____

COMMONWEALTH OF VIRGINIA LAW REQUIRES THAT THE IMMUNIZATION HISTORY FORM AND TB SCREENING BE COMPLETED AND SUBMITTED TO SCHIFFERT HEALTH CENTER.

Instructions for students:

1. Download and print the Immunization History Form and have it completed and signed by a health care professional. An official immunization record from your doctor or another school will be accepted.
2. Please ensure you have completed all required sections listed prior to submission.
3. Log into the Healthy Hokies Portal (https://healthyhokies.healthcenter.vt.edu/) where you may upload and verify receipt of the form (allow 5 working days for data entry after anticipated receipt date) and view immunization data in case you are contacted about any deficiencies. You will be notified of any incomplete requirements by secure message.
4. Complete the **TB Risk Screen Online** in the portal. All students are required to complete this questionnaire.
5. If you are unable to upload your documents, you may mail or fax your documents. Visit https://healthcenter.vt.edu/about/contact_us.html for contact information.

Student Name:_____ DOB: ____/____/_____ University ID #:_____

Immunization History Form: Part II

[TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER]

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official of the required vaccines shall be acceptable in lieu of recording dates on this form, as long as the record is attached. For more information about immunization requirements or exemption forms: https://healthcenter.vt.edu/new_student.html

Required Vaccines	**Record Complete Dates (mm/dd/yyyy) of Vaccine Doses Given**			
Tdap (NOT DTaP. Dose required **ON or AFTER** 10th birthday)	Date: _____/ _____/_____			
Tetanus Booster (Td or Tdap) ☐ Td ☐ Tdap	Date: _____/ _____/_____	Tetanus vaccine is required within the last 10 yrs. Td or Tdap are acceptable. **Booster not required if Tdap was within the last 10 yrs.**		
Measles, Mumps, Rubella (MMR) Vaccine: First dose received **AFTER** 1st birthday	1) Date: _____/ _____/_____	2) Date: ____/_____/_____		
Measles (Rubeoloa)	1) Date: _____/ _____/_____	2) Date: ____/ ____/_____	OR titer indicating immunity. **Must attach lab results.**	
Rubella	1) Date: _____/ _____/_____		OR titer indicating immunity. **Must attach lab results.**	
Mumps	1) Date: _____/ _____/_____	2) Date: ____/ _____/_____	OR titer indicating immunity. **Must attach lab results.**	
Hepatitis B or Combination Hepatitis A and B vaccine (Twinrix) **OR** titer indicating immunity. **Must attach lab results.**	Check one: ☐ 2-dose series ☐ 3-dose series	1) Date: _____/ _____/_____	2) Date: _____/ _____/_____	3) Date: _____/ _____/_____
Polio (IPV, OPV) : at least one dose **on or after 4th birthday**	1) Date: _____/ _____/_____	2) Date: ____/ _____/_____	3) Date: ____/ ____/_____	4) Date: ____/ ____/_____
Meningococcal Vaccine: Initial dose OR a booster dose must have been received **on or after** 16th birthday. **Only for students < 22 years of age.**	1) Date: _____/ _____/_____	2) Date: ____/ _____/_____	**Please Note:** Serogroup B Meningococcal Vaccine does not meet this requirement	

Strongly Recommended Vaccines (Not Required)	**Record Complete Dates (mm/dd/yyyy) of Vaccine Doses Given**			
Hepatitis A	1) Date: ____/ ____/ _____	2) Date: ____/ ____/ _____		
Human Papillomavirus Vaccine (HPV)	1) Date: ____/ ____/ _____	2) Date: ____/ ____/ _____	3) Date: ____/ ____/ _____	
Serogroup B Meningococcal Vaccine ☐ MenB-4C (BEXSERO) ☐ MenB-FHpb (TRUMENBA)	1) Date: _____/ _____/ _____	2) Date: _____/ _____/ _____	3) Date: _____/ _____/ _____	
Varicella (2 doses, one month apart) **OR** Date of disease: _____/ _____/ _____	1) Date: _____/ _____/ _____	2) Date: _____/ _____/ _____	OR titer indicating positive immunity**. Must attach lab results.**	
COVID-19 Vaccine Please list dates and manufacturer for each dose on the lines provided (ex. Pfizer, Moderna, J&J)	1) Date: _____/ _____/ _____ Mfr: _____	2) Date: _____/ _____/ _____ Mfr: _____	3) Date: _____/ _____/ _____ Mfr: _____	4) Date: ____/ _____/ _____ Mfr: _____

Tuberculosis Testing (Required only if TB Screening Questionnaire is Positive)	**All steps must be after 3/1 (Fall start) or 7/1 (Spring start)**			
Tuberculosis testing result: IGRA **required** for students from any country listed on page 2. If PPD Test is chosen, you must include the date placed, read, and reading size.	Result: ☐ Positive ☐ Negative	Test Method: ☐ IGRA ☐ PPD	Date of Test/Placed: ___/ ____/_____ Date PPD Read: ___/ ____/_____	Must attach copy of result for IGRA or PPD. Reading size (in mm): _____
Chest X-ray results. **Required only if Tuberculosis Testing Positive.**	☐ Positive	☐ Negative	Date of Test: ____/ ____/_____	Must attach copy of report.
Treatment for TB disease or Latent TB infection	☐ Completed	☐ Ongoing	Dates of treatment: Must attach documentation. ____/ ____/_____ to ____/ ____/_____	
All students with a positive IGRA or TST and no signs of active disease on chest x-ray should receive education and treatment recommendations for Latent Tubercolusis Infection (LTBI). LTBI must be reported in VA: http://www.vdh.virginia.gov/tuberculosis				

Signature of health care provider is required.

Printed Name: _____ Phone: _____

Address: _____

Signature: _____ Date: _____