MISSOURI VALLEY
COLLEGE

Dear Students:

On behalf of the Student Health Services staff, welcome to Missouri Valley College!

Vaccine preventable illness continues to occur on college campuses across the country. To help ensure the health and well-being of our community, Missouri Valley College has adopted an immunization policy. This policy is based on the recommendations of the American College Health Association (ACHA) for immunization practice. For more information on ACHA recommendations, visit http://www.acha.org/Topics/vaccine.cfm.

The following are the required vaccination records for all students attending Missouri Valley College:

1. **Measles, Mumps, Rubella (MMR)**
   (2 doses)

2. **Tetanus, Diphtheria, Pertussis (Tdap)**
   (with last dose between ages 11-64 AND Td booster dose every 10 years)

3. **Meningococcal Tetravalent**

4. **Tuberculosis (TB) Screening Form**

5. **Meningitis Vaccination Waiver Form**
   (*Required only if individual has not received Meningococcal Tetravalent. Must be completed yearly)

6. **Tuberculosis Risk Assessment**
   (*Required yearly for individuals answering "yes" to any of the TB Screening Form questions. Must be completed yearly by a medical professional)

If you have any questions, please do not hesitate to contact me.

Sincerely,

Diane Weinreich, APRN, FNP

Diane Weinreich, APRN, FNP
Student Health Services
500 East College Street ● Marshall, MO 65340
Phone: (660) 831-4012 ● Fax: (660) 831-4039
weinreichd@moval.edu

Student Name: _____

Date of Birth: ____ / ____ / _____ Student ID# (if known): _____

This section to be completed and signed by a health care provider. All records must be in English.

MEASLES, MUMPS, RUBELLA (MMR)

Two doses required at least 28 days apart for students born after 1956.

1. Dose 1 given at age 12 months or later ____ / ____ / _____
2. Dose 2 given at least 28 days after first dose ____ / ____ / _____

TETANUS, DIPHTHERIA, PERTUSSIS (Tdap)

Tdap booster required for ages 11-64 unless contraindicated.

1. Primary series completed? Yes ___ No ___ Date of last dose in series: ____ / ____ / _____
2. Date of most recent booster dose: ____ / ____ / _____ Type of booster: Td _____ Tdap_____

MENINGOCOCCAL QUADRIVALENT (*OR WAIVER)

One or 2 doses for all students, revaccinate every 5 years if increased risk continues.

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).

   Dose #1 ____ / ____ / _____ | Dose #2 ____ / ____ / _____

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

   Dose #1 ____ / ____ / _____

Healthcare Provider Certification (*Licensed Medical Doctor)

Full Name: _____

Address: _____

_____

_____

Phone: (____) ____ - _____

Signature:_____ Date: ____ / ____ / _____

Student Name: _____

Date of Birth: ____ / ____ / _____ Student ID# (if known): _____

This section to be completed by the student. All records must be in English.

TUBERCULOSIS (TB) SCREENING FORM

a. Have you ever had a positive TB skin test? Yes No
b. Have you ever had close contact with anyone who was sick with TB? Yes No
c. Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years? Yes No
d. Have you ever traveled to/in one or more of the countries listed below? Yes No
e. Have you ever been vaccinated with BCG? Yes No

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

f. Did you answer YES to any of the questions above? Yes No

- If yes, **Missouri Valley College** requires that a health care provider complete the **Tuberculosis Risk Assessment**, found starting on page 4. This form must be completed once per academic year
- If No, the **Tuberculosis Risk Assessment** does not need to be completed; you do not require a TB test.

Signature:_____ Date: ____ / ____ / _____

Student Name: _____

Date of Birth: ____ / ____ / _____ Student ID# (if known): _____

This section to be completed by the student. All records must be in English.

5. MENINGITIS VACCINATION WAIVER FORM

*Required only if individual has not received Meningococcal Tetravalent. Must be completed yearly.

By signing below, I understand the risks of the meningitis disease, including but not limited to, hearing loss, learning disability, brain damage, & death. I fully recognize that there may be direct, indirect, or inherent risks and hazards involved in not being vaccinated with the Meningococcal Tetravalent and attending class and/or residing on campus. I also understand that Missouri Valley College encourages that all students have the vaccination, however I choose not to get the vaccination despite the possible dangers and risks. It is with full knowledge of the facts and circumstances that I release and hold harmless Missouri Valley College, its employees, agents, and representatives from any liability whatsoever arising from not receiving the vaccination; from any claims and/or actions that may arise from injury or harm to me, and understand that this waiver shall bind the members of my family and/or spouse, if I am alive, as well as my estate, family, heirs, administrators, or representatives, if I am deceased.

Student Date of Birth: ____ / ____ / _____

Student Signature: _____

Parent/Guardian Signature _____
(if student is under the age of 18)

Date Signed: ____ / ____ / _____

Student Name: _____

Date of Birth: ____ / ____ / _____ Student ID# (if known): _____

This section to be completed and signed by a health care provider. All records must be in English.

TUBERCULOSIS RISK ASSESSMENT

*Required only if individual answered YES to Tuberculosis (TB) Screening Form. Must be completed yearly.

Persons with any of the following are candidates for either Mantoux Tuberculin Skin test (TST) or Interferon Gamma Release Assay (IGRA).

Recent close contact with someone with infections TB disease	**YES**	**NO**
Foreign-born from (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America)	**YES**	**NO**
Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease	**YES**	**NO**
HIV/AIDS	**YES**	**NO**
Organ transplant recipient	**YES**	**NO**
History of illicit drug use	**YES**	**NO**
Resident, employee, or volunteer in a high-risk of progressing to TB disease if Infected [e.g., diabetes mellitus, silicosis, head, neck, or lung cancer, hematologic or Reticuloendothelial disease such as Hodgkin's disease or leukemia , end stage renal Disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body Weight (ie., 10% or more below ideal for the given population)]	**YES**	**NO**

1. **Does the student have signs or symptoms of active TB disease? YES_____ NO_____**

   If **NO,** proceed to 2 **or** 3. If **YES**, proceed with additional evaluation to exclude active TB disease including TST, CXR and sputum evaluation as indicated. For history of **BCG vaccination**, it is recommended to proceed with Interferon Gamma Release Assay (TST could give a false positive with history of BCG vaccination). If positive TST has been noted in the past, IGRA is mandatory.

2. **Tuberculosis Skin Test (TST)**

   TST results 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: ____ / ____ / _____

   Results:_____mm of induration **Interpretation: Positive_____Negative_____

   Date Given: ____ / ____ / _____ Date Read: ____ / ____ / _____

   Results:_____mm of induration **Interpretation: Positive_____Negative_____

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____ / ____ / _____ (specify method) QFT-G QFT-GIT T-Spot Other_____

Result: negative_____ positive_____ indeterminate_____ borderline_____ (T-Spot only)

Date Obtained: ____ / ____ / _____ (specify method) QFT-G 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_____

Interpretation Guidelines

>5mm is positive:

1. Recent close contacts of an individual with infectious TB
2. Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
3. Organ transplant recipients
4. Immunosuppressed persons: taking >15mg/day of prednisone for >1 month; taking TNF-α antagonist
5. Persons with HIV/AIDS

>10mm is positive:

1. Persons born in a high prevalence country or who resided in one of a significant* amount of time
2. History of illicit drug use
3. Mycobacteriology laboratory personnel
4. History of resident, worker, or volunteer in a high-risk congregate setting
5. Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes.

>15mm is positive:

1. Persons with no known risk factors for TB disease

It is the policy of Missouri Valley College that treatment for latent TB infection should be initiated before coming on campus. This policy is recommended by the American College Health Association.

Healthcare Provider Certification (*Licensed Medical Doctor)

Full Name: _____

Address: _____

_____

_____

Phone: (____) ____ - _____

Signature:_____ Date: ____ / ____ / _____