VILLANOVA UNIVERSITY

STUDENT HEALTH SERVICES

Dear Undergraduate Student,

Student Health Services (SHC) would like to welcome you to Villanova University (VU). All mandatory health forms are in this packet and on the Villanova Student Health Portal.

All health forms must be completed and uploaded to the Student Health Portal before classes start. See the instructions below. If you do not comply, you will be unable to register for next semester's classes.

Deadlines for Submission:

- Fall Enrollment: July 1st
- Spring Enrollment: January 1st

Villanova requires all full-time undergraduate students to submit proof of their immunizations. The Villanova Student Health Portal immunization tab lists immunizations required by the State of Pennsylvania and those that VU highly recommends. Your documentation should include all REQUIRED vaccines listed or positive titers. If you have not received all the REQUIRED vaccines, you must obtain them before classes start.

All VU students are strongly encouraged to use the included physical exam form; however, you may substitute an official copy of your physical exam record from your health care provider if the exam was performed in the past one year, specifically 365 days prior July 1st. The provider form should include all the same information requested on the VU physical exam form.

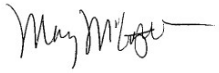
Directions to submit forms to the Student Health Portal:

- Scan or take a picture of each form. Save the images on your computer or phone. Do not use special characters when naming your file.
- Log in to the Villanova Student Health Portal at villanova.medicatconnect.com. You will use your VU issued username and password to login to the portal.
- **The welcome page contains a check list for new students. Please carefully review the instructions as directed by the site.**

Once all forms have been uploaded, and all digital forms have been filled out, you will receive a confirmation email from the Student Health Center confirming that your health record is complete. Please do not send original forms to VU; instead, maintain them for your records if there is a problem with the image quality and you need to resubmit them.

Thank you in advance for your cooperation, and best of luck in your studies.

Sincerely,



Dr. Mary McGonigle
Director, Student Health Services

Student Health Services
800 East Lancaster Ave Villanova, PA 19085
Phone: 610-519-4070
Website: villanova.edu/studenthealthservices

Student ID: _____
Student Cell Phone: _____
Send us a message: studenthealthcenter@villanova.edu
Student Medical Portal: villanova.medicatconnect.com

Physical Examination Form

Last Name: _____First Name _____ Preferred Name_____ Date of Birth:_____

Instructions

The student named above has been admitted to Villanova University. While in attendance at VU, the student may be eligible for and receive health care services at Villanova University, Student Health Center (SHC). Is it beneficial for the SHC to have knowledge of the student's current and past medical history. In addition, the student's immunization history must be up to date as defined by Pennsylvania law.

Providers are asked to complete, sign, and return this form to the student. Students are asked to upload the form to the Villanova University Student Medical Portal (villanova.medicatconnect.com) by July 1st, for Fall Enrollment or January 1st, for Spring Enrollment. Failure to submit a completed Health Record will result in the inability to register for the next semester classes.

Health Conditions

Is this student currently under treatment for any medical or mental health condition? If yes, please include the condition and treatment plan:

Has this student suffered any major illness or injury in the past that we should be aware of?

Do you have any recommendations for this student's health care while at Villanova University?

Physical exam must be within 365 days prior to July 1st, 2025

Date of Physical Exam: _____ Height: _____ Weight: _____ BMI: _____ Blood Pressure: _____ Pulse: _____.

General	WNL	Remarks:		Breasts	WNL	Remarks:	
HEENT	WNL	Remarks:		Abdomen	WNL	Remarks:	
Thyroid	WNL	Remarks:		GU	WNL	Remarks:	
Neck	WNL	Remarks:		Musculoskeletal	WNL	Remarks:	
Lungs	WNL	Remarks:		Pelvic *(If indicated)*	WNL	Remarks:	
Cardio	WNL	Remarks:		Neurological	WNL	Remarks:	

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Student Name: _____
Student ID: _____

Physical Examination Form

Allergies

Please list all allergies to medications, foods, and other known reactions.
(If the student has no known allergies, please check the box below.)

- ❑ The student has no known allergies to medications.
- ❑ The student has no known allergies to foods.

Medication(s):		
Food(s):		
Do they have an EpiPen?	❑ Yes ❑ No	Reason:

Current Medication

(List of all prescription and nonprescription medications, including vitamins & herbal supplements, including dose and times per day.)

Name	Dose	Frequency	Related Diagnosis

Fit for Sport

(This section is MANDATORY, physical will not be considered complete until completed by clinician)

Is this student medically qualified to participate in intercollegiate, intramural or club sport activities? Yes _____ No _____
If no, please explain why: _____
_____
_____

Signature of Provider: _____ Printed Name : _____ Date Of Completed Exam: _____

Mailing Address: _____ Office Phone : _____

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Student Email: _____

Tuberculosis (TB) Risk Assessment Questionnaire	
1. Did you ever receive a BCG vaccine as a child?	❒ No ❒ Yes ❒ Unsure
2. Have you ever had close contact with people who are known or suspected of having active TB disease?	❒ No ❒ Yes
3. Have you ever had a history of a positive PPD skin test or IGRA blood test?	❒ No ❒ Yes
4. Have you had temporary or permanent residence of ≥1 month in a country with a high TB rate? (High prevalence countries are any countries other than the United States, Canada, Australia, New Zealand, and those in Northern Europe or Western Europe)	❒ No ❒ Yes
5. Are you a recent arrival (<5 years) from one of the high prevalence areas? If yes, please indicate date of arrival:	❒ No ❒ Yes
6. Have you had frequent or prolonged visits (for more than one month) to one or more of the high prevalence countries of? (If yes, list the country/countries): _____	❒ No ❒ Yes
7. Have you been a health care worker, volunteer, resident and/or employee of high-risk congregate settings or served clients who are at increased risk of active TB disease (e.g., correctional facilities, long-term care facilities, homeless shelter, substance abuse treatment, rehabilitation facility)?	❒ No ❒ Yes
8. 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?	❒ No ❒ Yes
9. Does the student have signs or symptoms of active pulmonary tuberculosis disease? (i.e. cough (especially if lasting for 2-3 weeks or longer) with or without sputum production, Coughing up blood (hemoptysis), Chest pain, Loss of appetite, Unexplained weight loss, unusual weakness, extreme fatigue, Night sweats)	❒ No ❒ Yes

If the answer to all the above questions is **NO**, no further testing is required. If the answer is **YES** to any of the above questions, Villanova University requires TB testing before arriving on campus at the start of the semester. Nursing students may require additional TB Testing. Please check with the Fitzpatrick School of Nursing. Failure to provide results of the TB testing will put your school account on hold and you will not be able to register for Spring semester classes in the Fall.

Provider's Signature: _____ **Date:**_____

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Tuberculosis (TB) Testing Form

Clinicians should review and verify information on the TB Screening Form. Persons answering **YES** to any of the questions are candidates for **EITHER** the Mantoux tuberculin skin test (PPD) **OR** Interferon Gamma Release Assay (IGRA) blood test unless a previous positive test is documented.

Tuberculin Skin Test (PPD)

(PPD result should be recorded as actual millimeters of induration, transverse diameter; if no induration, write "0")

Date Given: _____ Date Read: _____ Result: _____ mm of induration

Provider's Signature: _____

Interferon Gamma Release Assay (IGRA)

Date Obtained: _____ Specify Method: ☐QFT-GIT ☐ T-Spot ☐other____ Result: ____negative ____positive _____indeterminate ____borderline (T-Spot only)

Chest X-Ray: (Required if PPD 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.

Provider's Signature: _____ **Date:**_____

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Email: _____

Vaccine Requirements for First Year and Transfer Students

The Commonwealth of Pennsylvania and Villanova University require full-time students, part-time students, and all students on a visa to be immunized against certain communicable diseases. All dates must include month, day, and year. To comply, you must upload official immunization documentation from your provider's office in addition to, manually inputting the dates for required vaccines under the "immunization tab" on the Student Health Portal at villanova.medicatconnect.com.

List of Required Vaccines	
Hepatitis B 3 or 4 dose series– laboratory evidence of immunity is acceptable in lieu of immunization dates.	**3 - Dose Series:** Birth, 1 month following first dose, and 6 months following first dose. **4 - Dose Series**: Birth, 6-weeks of age, 14-weeks of age and 6 months of age.
MMR (Measels, Mumps & Rubella) Or individual vaccines or titers	**Dose #1:** ***Must*** be given on or after the 1st birthday. **Dose #2**: ***Must*** be given greater than or equal to 28 days (about 4 weeks) after the first dose or laboratory evidence of immunity is acceptable.
Varicella Vaccination Laboratory evidence for immunity is acceptable in lieu of immunization or history of chicken pox.	**Dose #1:** First dose on or after the first birthday **Dose #2:** At least 28 days (about 4 weeks) after first dose For the history of chickenpox, please provide medical record documentation signed by the provider or laboratory evidence of immunity.
TDAP (Tetanus, Diphtheria, Pertussis)	Tdap must have been given at, or after the age of 7 **If Tdap was given before 2014 (greater than or equal to 10 years ago), you must receive a current Td or Tdap.*
Meningococcal Quadrivalent (Meningitis A, C, W, Y) Required of students 21 years of age and younger.	One Dose of Meningitis ACWY (formerly MCV4) ON OR AFTER AGE 16 or a signed medical waiver.
Meningococcal Group B (Bexsero ***or*** Trumenba)	**Trumenba:** 2 or 3 dose series, for those not at risk, 2 doses, second dose 6 months *after* the first dose. Those with increased risk, 3 doses. Second dose 1-2 months *after* first dose. Third dose 6 months *after* the first. **Bexsero:** 2 doses, second dose at least 6 months after the first dose.
Meningococcal ABCWY - Penbraya (Alternative vaccine for above two meningitis vaccines, contains ACWY and B vaccines together)	Two dose series: administered 6 months apart

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List of Required Vaccines – con't	PA State Requirements
Tuberculosis Screening	**Option #1:** Low Risk Assessment Questionnaire - Filled out and signed by medical provider. **Option #2:** TB Skin Test - Test performed by medical provider and proof of negative result required. **Option #3:** QuantiFERON Gold - Laboratory blood test *If TB Skin test or QuantiFERON Gold test produces positive results, a subsequent chest X-Ray will be required.*
Polio Vaccine – IPV/OPV	Please provide the last date of primary series.
List of Recommended/Additional Immunizations	
Covid-19 Vaccine & Booster	Accepted Vaccines: Pfizer-BioNTech - Moderna - Johnson&Johnson's Janssen - WHO Approved List
Gardasil (HPV) Humna Papillomavirus	3 doses over 6 months
Hepatitis A	2 doses at least 6 months apart
Typhoid	
Yellow Fever	
BCG	

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Student Cell Number: _____
Student Email: _____

Vaccination Accommodation Request Form

*Complete this form and then upload it (use document type "Student Vaccination Accommodation/Exemption Form"), along with all supporting documentation to **villanova.medicatconnect.com** to be considered for an accommodation from the University's standard vaccination requirements for medical reasons or due to a sincerely held religious, moral, or ethical belief.*

I hereby authorize the release of supporting information to the University for the purpose of evaluating my vaccination accommodation request. If I am requesting medical accommodation, I further authorize the University to seek clarification of this documentation, if necessary, by contacting my health care provider. If my health care provider requires that a HIPAA release be signed before releasing information related to my accommodation request, I agree that I will promptly execute the HIPAA release.

Please Print Name: _____

Villanova E-Mail: _____

Provide a description of the requested accommodation (indicate the vaccine requirement(s) for which you are requesting an accommodation):

_____

_____

Provide a short explanation of the reason for the requested accommodation (indicate whether you are seeking an accommodation for medical reasons or due to a sincerely held religious, moral, or ethical belief):

_____

_____

Signature: _____

Parent/Guardian Signature (if student is under 18): _____

For medical accommodation requests, please upload documentation from your primary care provider of the medical condition warranting the accommodation along with this form. The letter must include the provider's name, address, and phone number.

For religious/moral/ethical accommodation requests, please upload a statement or other documentation explaining the basis of your objection to the specific vaccination requirement(s) indicated above.

Please note: If you are requesting an accommodation from the meningococcal disease vaccination requirement, you will also be required to complete and submit the Meningococcal Vaccination Accommodation/Exemption Form.

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Meningococcal Disease Accommodation Form

I have been given a copy and have read, or have had explained to me, the information in the Meningococcal Vaccine Information Statement for meningococcal disease. I have had a chance to ask questions to a health care provider that were answered to my satisfaction. I believe that I understand the risks associated with meningococcal disease and the availability and effectiveness of the vaccine required. However, I am requesting exemption pursuant to the Pennsylvania College and University Student Vaccination Act, 35 P.S. § 633.1 et seq.

_____

Signature of Student Printed Name Date

_____

Signature of Parent/Guardian *(if student is a minor)* Printed Name Date

_____

Signature of Physician Printed Name Date

Meningococcal ACWY Vaccine:
What You Need to Know

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Meningococcal ACWY vaccine can help protect against **meningococcal disease** caused by serogroups A, C, W, and Y. A different meningococcal vaccine is available that can help protect against serogroup B.

Meningococcal disease can cause meningitis (infection of the lining of the brain and spinal cord) and infections of the blood. Even when it is treated, meningococcal disease kills 10 to 15 infected people out of 100. And of those who survive, about 10 to 20 out of every 100 will suffer disabilities such as hearing loss, brain damage, kidney damage, loss of limbs, nervous system problems, or severe scars from skin grafts.

Meningococcal disease is rare and has declined in the United States since the 1990s. However, it is a severe disease with a significant risk of death or lasting disabilities in people who get it.

Anyone can get meningococcal disease. Certain people are at increased risk, including:

- Infants younger than one year old
- Adolescents and young adults 16 through 23 years old
- People with certain medical conditions that affect the immune system
- Microbiologists who routinely work with isolates of *N. meningitidis*, the bacteria that cause meningococcal disease
- People at risk because of an outbreak in their community

2. Meningococcal ACWY vaccine

Adolescents need 2 doses of a meningococcal ACWY vaccine:

- First dose: 11 or 12 years of age
- Second (booster) dose: 16 years of age

In addition to routine vaccination for adolescents, meningococcal ACWY vaccine is also recommended for **certain groups of people**:

- People at risk because of a serogroup A, C, W, or Y meningococcal disease outbreak
- People with HIV
- Anyone whose spleen is damaged or has been removed, including people with sickle cell disease
- Anyone with a rare immune system condition called "complement component deficiency"
- Anyone taking a type of drug called a "complement inhibitor," such as eculizumab (also called "Soliris"®) or ravulizumab (also called "Ultomiris"®)
- Microbiologists who routinely work with isolates of *N. meningitidis*
- Anyone traveling to or living in a part of the world where meningococcal disease is common, such as parts of Africa
- College freshmen living in residence halls who have not been completely vaccinated with meningococcal ACWY vaccine
- U.S. military recruits

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of meningococcal ACWY vaccine**, or has any **severe, life-threatening allergies**

In some cases, your health care provider may decide to postpone meningococcal ACWY vaccination until a future visit.

There is limited information on the risks of this vaccine for pregnant or breastfeeding people, but no safety concerns have been identified. A pregnant or breastfeeding person should be vaccinated if indicated.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting meningococcal ACWY vaccine.

Your health care provider can give you more information.

4. Risks of a vaccine reaction

- Redness or soreness where the shot is given can happen after meningococcal ACWY vaccination.
- A small percentage of people who receive meningococcal ACWY vaccine experience muscle pain, headache, or tiredness.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/vaccines**.

Meningococcal B Vaccine:

What You Need to Know

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Meningococcal B vaccine can help protect against **meningococcal disease** caused by serogroup B. A different meningococcal vaccine is available that can help protect against serogroups A, C, W, and Y.

Meningococcal disease can cause meningitis (infection of the lining of the brain and spinal cord) and infections of the blood. Even when it is treated, meningococcal disease kills 10 to 15 infected people out of 100. And of those who survive, about 10 to 20 out of every 100 will suffer disabilities such as hearing loss, brain damage, kidney damage, loss of limbs, nervous system problems, or severe scars from skin grafts.

Meningococcal disease is rare and has declined in the United States since the 1990s. However, it is a severe disease with a significant risk of death or lasting disabilities in people who get it.

Anyone can get meningococcal disease. Certain people are at increased risk, including:

- Infants younger than one year old
- Adolescents and young adults 16 through 23 years old
- People with certain medical conditions that affect the immune system
- Microbiologists who routinely work with isolates of *N. meningitidis*, the bacteria that cause meningococcal disease
- People at risk because of an outbreak in their community

2. Meningococcal B vaccine

For best protection, more than 1 dose of a meningococcal B vaccine is needed. There are two meningococcal B vaccines available. The same vaccine must be used for all doses.

Meningococcal B vaccines are recommended for people 10 years or older who are at increased risk for serogroup B meningococcal disease, including:

- People at risk because of a serogroup B meningococcal disease outbreak
- Anyone whose spleen is damaged or has been removed, including people with sickle cell disease
- Anyone with a rare immune system condition called "complement component deficiency"
- Anyone taking a type of drug called a "complement inhibitor," such as eculizumab (also called "Soliris"®) or ravulizumab (also called "Ultomiris"®)
- Microbiologists who routinely work with isolates of *N. meningitidis*

These vaccines may also be given to anyone 16 through 23 years old to provide short-term protection against most strains of serogroup B meningococcal disease, based on discussions between the patient and health care provider. The preferred age for vaccination is 16 through 18 years.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of meningococcal B vaccine**, or has any **severe, life-threatening allergies**
- Is **pregnant or breastfeeding**

In some cases, your health care provider may decide to postpone meningococcal B vaccination until a future visit.

Meningococcal B vaccination should be postponed for pregnant people unless the person is at increased risk and, after consultation with their health care provider, the benefits of vaccination are considered to outweigh the potential risks.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting meningococcal B vaccine.

Your health care provider can give you more information.

4. Risks of a vaccine reaction

- Soreness, redness, or swelling where the shot is given, tiredness, headache, muscle or joint pain, fever, or nausea can happen after meningococcal B vaccination. Some of these reactions occur in more than half of the people who receive the vaccine.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

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