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 instructions below. If you do not comply, you will be unable to register for the next semester's classes.

Deadlines for Submission:

- Fall Enrollment: July 1, 2024
- Spring Enrollment: January 1, 2025

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 1, 2024. 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: www.villanova.edu/studenthealthservices
Send us a message: studenthealthcenter@villanova.edu
Student portal: villanova.medicatconnect.com

Student Name:_____
Student ID: _____
Date of Birth: _____
Cell Number: _____
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	PA State Requirements
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 1 month after the first dose.
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.

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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 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 1, 2024, for Fall Enrollment or January 1, 2025, for Spring 2025 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, 2024

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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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 _____

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

Mailing Address: _____ Office Phone : _____

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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 persons known or suspected to have 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. 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 October 2024.

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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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 a 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 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