Health Form B

Fones School of Dental Hygiene, School of Nursing, and PA Institute

This form must be completed in its entirety by a licensed physician, physician assistant, or nurse practitioner annually for all dental hygiene, nursing, and PA students. Students must maintain a copy of the completed form for their records to be submitted to their program's clinical tracking system.

Student Last Name	Student First Name	UB ID#	Date of Birth: ____/____/____ Month Day Year
E-mail	Phone ( ) -	Sex Assigned at Birth	Gender Identity
Clinical Program (Choose One): ❒ Fones School of Dental Hygiene ❒ School of Nursing ❒ PA Institute			

IMMUNIZATION HISTORY: Must be completed by Health Care Provider

All titer labs must be up to date within the last **3 years** to be accepted.

Lab results for titers **must be attached with submission** of the form.

Vaccine requirement exemptions requests should be submitted using the appropriate form through Student Health Services.

MEASLES, MUMPS, RUBELLA (MMR) – Proof of vaccination **AND** evidence of immunity through titer required.

Required for All DH, Nursing, & PA Students	Measles, Mumps, Rubella (MMR) Vaccination • First dose must be given on or after your first birthday; second dose must be at least 28 days beyond first dose to be accepted. If no records available, complete titer documentation below.	Dose #1: ____/____/____ Month Day Year	Dose #2: ____/____/____ Month Day Year	Booster Dose: (if indicated): ____/____/____ Month Day Year
	Provide evidence of immunity to each individual disease through titer and attach lab results with submission. If not immune, contact Student Health Services for further guidance.	Measles: ❒ Immune Date ____/____/____ Month Day Year Mumps: ❒ Immune Date ____/____/____ Month Day Year Rubella: ❒ Immune Date ____/____/____ Month Day Year		

VARICELLA – Proof of vaccination or history of disease **AND** evidence of immunity through titer required.

Required for All DH, Nursing, & PA Students	Varicella Vaccination Proof • First dose must be given on or after your first birthday to be accepted		Dose #1: ____/____/____ Month Day Year	Dose #2: ____/____/____ Month Day Year
	In lieu of vaccination you may provide proof of history of disease. • Confirmation must include date of illness and initials by MD/DO/APRN/PA	Date of Disease ____/____/____ Month Day Year Provider Initials _____		
	Provide evidence of immunity through titer and attach lab results with submission. If not immune, contact Student Health Services for further guidance.	Varicella: ❒ Immune Date ____/____/____ Month Day Year		

MENINGOCOCCAL– Vaccination required of all students living in university dormitories **only**.

Required for All Residential Students	Meningitis Vaccine (MCV 4) • Must cover strains A, C, Y, W-135 (Menactra, Menveo or Nimenrix)	Dose #1: ____/____/____ Month Day Year	Dose #2: ____/____/____ Month Day Year
Required for All Commuter Students	Exemption to Meningococcal vaccine: ❒ I will not be living in university-owned housing ❒ I am over 23 years of age		

HEPATITIS B – Proof of complete vaccination (3 doses) **AND** evidence of immunity by antibody titer required.

Required for All DH, Nursing, & PA Students	Hepatitis B Vaccination Proof If no records available, complete titer documentation below.	Dose #1: ____/____/____ Month Day Year	Dose #2: ____/____/____ Month Day Year	Dose #3: ____/____/____ Month Day Year
	Provide evidence of immunity through titer and attach lab results with submission. If not immune, contact Student Health Services for further guidance.	Hep B: ❒ Immune Date ____/____/____ Month Day Year • Must be a Hep B surface antibody		
Required for PA students ONLY.	Provide documentation of Hepatitis B Surface antigen testing. • Required annually for 2nd and 3rd year PA students.	Date of Antigen Testing: ____/____/____ Month Day Year		

TETANUS-DIPTHERIA-PERTUSSIS– Proof of Tdap vaccination **within the past 10 years** required.

Required for All DH, Nursing, & PA Students	Tdap Vaccination Proof • After initial Tdap vaccine, Td or Tdap is an acceptable booster.	Most Recent Tdap: ____/____/____ Month Day Year

COVID-19– COVID-19 vaccination highly recommended for DH, Nursing, and PA Students. All students participating in DH, Nursing, and PA programs are encouraged to remain up to date with current CDC Covid-19 Vaccination recommendations.

Highly Recommended for All DH, Nursing, & PA Students	If vaccinated, please provide documentation of date of vaccination and product name (example: 2024-2025 Moderna)	Dose #1: ____/____/____ Month Day Year Product Name:	Dose #2: ____/____/____ Month Day Year Product Name:	Booster: ____/____/____ Month Day Year Product Name:	Most Recent: ____/____/____ Month Day Year Product Name:
	If not vaccinated, please attest that you have no record of receiving the COVID-19 Vaccination. ❒ I have not received COVID-19 vaccination.				

TUBERCULOSIS (TB) Screening – Proof of IGRA testing **OR** Two-Step PPD required annually.

Required for All DH, Nursing, & PA Students	Option 1	Provide evidence of IGRA testing and attach lab results with submission. • Recommended if prior BCG vaccination.	Test: ❒ QuantiFERON ❒ T-Spot Results: ❒ Negative ❒ Positive Date ____/____/____ Month Day Year If positive, contact Student Health Services for further guidance.	
	Option 2	Provide evidence of a Two-Step PPD. If positive, contact Student Health Services for further guidance.	PPD #1 Planted: ____/____/____ Month Day Year Read: ____/____/____ Month Day Year Interpretation: ❒ Positive ❒ Negative	PPD #2 Planted: ____/____/____ Month Day Year Read: ____/____/____ Month Day Year Interpretation: ❒ Positive ❒ Negative

Influenza- Proof of influenza vaccination required annually.

Required for All DH, Nursing, & PA Stud.	Influenza Vaccination Proof • Must be updated annually by October 15th. • Attach evidence of flu vaccination with submission.	Most Recent Flu Vaccination: ____/____/____ Month Day Year Lot #: _____

Physician/Health Care Provider's Information (Please print clearly):			
Last Name	First Name		Phone: ( ) -
Street	City	State	Zip Code
Health Care Provider's Signature and Credentials:			Date: ____/____/____ Month Day Year