Saint Vincent Seminary & Archabbey

300 Fraser Purchase Road,
Latrobe, Pennsylvania 15650

PRE-ENTRANCE HEALTH FORMS

for all Seminary Students, and,
Postulants, Novices, and Visitors who reside in the Archabbey

No student may reside on campus or register for classes until these forms are submitted.

SEND COMPLETED FORMS TO:

Saint Vincent Seminary
Academic Dean
300 Fraser Purchase Road,
Latrobe, Pennsylvania 15650

or electronically to:
email: deborah.taylor@stvincent.edu
or
fax: 724-805-2880

-OR-

Saint Vincent Archabbey
Director of Vocations
300 Fraser Purchase Road,
Latrobe, Pennsylvania 15650

or electronically to:
email: vocation@stvincent.edu

DUE DATES FOR SEMINARY STUDENTS:

JANUARY 1st for students beginning at SVS in January (Spring Semester) - ***JULY 1st*** for students entering SVS in August (Fall Semester)

STUDENT'S NAME:_____ Birth date:____/____/____
Last *First* *Middle* *M* *D* *Y*

STUDENT ID #: |___|___|___|___|___|___|___| *Assigned by Dean's office*

Permanent address:_____ City:_____ State/Prov: _____

Country:_____ Telephone:_____ Email Address:_____

- When are you arriving at SVS? (circle one) Month :_____ YEAR:_____

Passport #_____ Nationality_____ Visa Type_____

Sevis # (For those with an I-20): _____

- Will you be registering for 3 or more classes your first semester at SVS? ☐ Yes ☐ No ☐ Not sure
- Program: _____
- Were you born in the U.S.? ☐ Yes ☐ No, I was born in _____
- Did you ever have Chickenpox? ☐ Yes – Month:_____Year_____ ☐ No, but I was vaccinated. ☐ No and I was not vaccinated.

Primary Contact	Secondary Contact
Name:	**Name:**
Relationship:	**Relationship:**
Home Phone:	**Home Phone:**
Work Phone:	**Work Phone:**
Cell Phone:	**Cell Phone:**

PAGE TO BE COMPLETED BY THE STUDENT

Name: _____ **Birth date:** ____/____/____ **SVS #:** _____
Last *First* *M* *D* *Y*

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

Student, Please answer the following questions:	**Circle One**
1) Have you ever had a **positive** TB test?	Yes No
2) Have you ever had **close contact** with persons known or suspected to have active TB disease?	Yes No
3) Were you **born** in one of the countries listed below? If yes, please CIRCLE the country.	Yes No
4) Have you had any **frequent or prolonged stays (30 days or more)** to one or more of the countries listed below? If yes, please CHECK ✔the country/ies below.	Yes No
5) Have you been a resident or employee of high-risk congregate settings (e.g., correctional facility, long-term care facility, homeless shelter)?	Yes No
6) Have you ever been a volunteer or health-care worker who served clients who are at risk for active TB disease?	Yes No
7) Have you ever been a member of any of the following groups that may have an increased incidence of latent TB infection or active TB disease: medically underserved, low-income, or abusing drugs and/or alcohol?	Yes No

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

Moderate to High Incidence Countries with TB incidence rates of ≥ 20 cases per 100,000 population in 2012. Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2012

If you answered YES to one or more of the above questions, Saint Vincent Seminary requires that a physician, nurse practitioner, or physician assistant complete the Physician's Evaluation for Tuberculosis (page 3). If you answered NO to all the above questions, *SKIP PAGE 3 and PROCEED TO PAGE 4.*

TO BE COMPLETED AND SIGNED BY A PHYSICIAN, PA OR NP IF PAGE 2 HAS ONE OR MORE "YES" ANSWERS.

PHYSICIAN'S EVALUATION FOR TUBERCULOSIS

Name:_____ **Birth date:**_____/_____/_____
Last *First* *M* *D* *Y*

1. Has the student had a TB TEST in the past? ☐ Yes ☐ No ☐ Unknown

2. Has the student had a POSITIVE TB test in the past? ☐ Yes ☐ No

   If YES, what test was positive: ☐ Interferon-Gamma Release Assay (IGRA) ☐ TB skin test – Result in mm:_____

   Date of Positive Test:_____/_____/_____
   M *D* *Y*

   Chest X-Ray Date:_____/_____/_____(Copy of Radiologist's report in ENGLISH must be attached.) Result: Normal ☐ Abnormal ☐
   M *D* *Y*

   Diagnosis: ACTIVE Tuberculosis ☐ Yes ☐ No LATENT Tuberculosis ☐ Yes ☐ No

   Treatment:_____ Completed successfully on_____/_____/_____
   M *D* *Y*

3. **TB SYMPTOM CHECK**

   Does the student have signs or symptoms of active pulmonary tuberculosis disease?

   No ☐ Proceed to #4

   Yes ☐ Check symptoms present & proceed with additional evaluation to exclude active tuberculosis disease including tuberculin testing, chest x-ray, and sputum evaluation as indicated.

   - ☐ Cough (especially if lasting 3 weeks or longer) with or without sputum production
   - ☐ Coughing up blood (hemoptysis)
   - ☐ Chest pain
   - ☐ Loss of appetite
   - ☐ Unexplained weight loss
   - ☐ Night sweats
   - ☐ Fever

4. **TB TEST -** If no history of a Positive TB test, perform one of the following tests within 6 months before start of classes:

   - TB Skin Test:_____/_____/_____TB Skin Test read:_____/_____/_____Result in mm:_____Neg ☐ Pos ☐
     M *D* *Y* *M* *D* *Y*
   - Interferon Gamma Release Assay (IGRA):_____/_____/_____ Neg ☐ Pos ☐ Copy of laboratory report must be attached.
     M *D* *Y*

5. **CHEST X-RAY** if TB test noted above is POSITIVE. **Copy of Radiologist's report in ENGLISH must be attached.**

   Date:_____/_____/_____ Interpretation: Normal ☐ Abnormal ☐
   M *D* *Y*

   Diagnosis: ACTIVE Tuberculosis ☐ Yes ☐ No LATENT Tuberculosis ☐ Yes ☐ No Other: _____

Not Valid unless signed and sealed: *Office Seal* (required)

Printed Name: _____

Signature: _____

Date: _____ Office Telephone: _____

TO BE COMPLETED BY A PHYSICIAN, PA, NP, OR RN

RECORD OF IMMUNIZATION

Student's Name:_____ **Birth date:**____/____/____
Last *First* *M D Y*

REQUIRED FOR ALL STUDENTS

MEASLES, MUMPS, RUBELLA (MMR) (students born BEFORE 1957 are exempt from the MMR requirement)

OR →	**2 doses of MMR VACCINE** **Dose 1 RECEIVED AFTER 1968 & ≥ 12 MONTHS OF AGE:**____/____/____ (M D Y) **Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE:**____/____/____ (M D Y)	**OR**	**LABORATORY PROOF OF IMMUNITY** (see below)
2 doses of MEASLES VACCINE **Dose 1 RECEIVED AFTER 1968 & ≥ 12 MONTHS OF AGE:**____/____/____ (M D Y) **Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE:**____/____/____ (M D Y)		**OR**	MEASLES Virus IgG Antibody test demonstrating immunity. Copy of laboratory report must be attached.
2 doses of MUMPS VACCINE **Dose 1 RECEIVED ≥ 12 MONTHS OF AGE:**____/____/____ (M D Y) **Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE:**____/____/____ (M D Y)		**OR**	MUMPS Virus IgG Antibody test demonstrating immunity. Copy of laboratory report must be attached.
1 dose of RUBELLA VACCINE **Dose 1 RECEIVED ≥ 12 MONTHS OF AGE:**____/____/____ (M D Y)		**OR**	RUBELLA Virus IgG Antibody test demonstrating immunity. Copy of laboratory report must be attached.

VARICELLA (Chickenpox)

2 doses of VARICELLA VACCINE **Dose 1 RECEIVED ≥ 12 MO OF AGE:**____/____/____ (M D Y) **Dose 2 RECEIVED ≥ 28 DAYS FROM 1ST DOSE:**____/____/____ (M D Y)	**OR**	**LABORATORY PROOF OF IMMUNITY** Varicella Zoster Virus (VZV) IgG Antibody test. Copy of laboratory report must be attached.	**OR**	**History of Chickenpox Infection** Date: ____/____/____ (M D Y) *History of injection alone is not acceptable for students entering the health care field. Must receive 2 doses of Varicella vaccine or provide proof of immunity to Varicella.*

TETANUS, DIPHTHERIA, PERTUSSIS

1 dose of TETANUS, DIPHTHERIA, PERTUSSIS VACCINE RECEIVED ≥ 11 YEARS OF AGE:____/____/____ (M D Y)

NOTE: Vaccination MUST include Pertussis to be acceptable. If not, revaccinate with Tdap.

Continued on next page

Student's Name: _____ Birth date: ____/____/____
Last First M D Y

Continued - REQUIRED FOR ALL STUDENTS

HEPATITIS B (NOTE: If beginning vaccination series, no need to accelerate dosing. Series can be completed at SVS)

3 doses of HEPATITIS B VACCINE Dose 1: ____/____/____ M D Y Dose 2: ____/____/____ M D Y Dose 3: ____/____/____ M D Y	**OR**	**3 doses of Combined HEPATITIS A & HEPATITIS B VACCINE** Dose 1: ____/____/____ M D Y Dose 2: ____/____/____ M D Y Dose 3: ____/____/____ M D Y	**OR**	**LABORATORY PROOF OF DISEASE OR IMMUNITY TO HEPATITIS B** Copy of laboratory report must be attached.

REQUIRED FOR ALL STUDENTS

MENINGOCOCCAL MENINGITIS A, C, Y, W-135

1 dose of Meningococcal Meningitis A, C, Y, W-135 Vaccine RECEIVED ≥ 16 YEARS OF AGE: ____/____/____ M D Y

NOTE: Give Booster dose if received before age 16

BRAND NAME of VACCINE: _____

OTHER VACCINATIONS (***NOT REQUIRED***):

MENINGOCOCCAL B (MenB) (for ages 16-23)

Dose 1: / / M D Y

HEPATITIS A

Dose 1: ____/____/____ M D Y Dose 2: ____/____/____ M D Y	**OR**	**Combined Hepatitis A & Hepatitis B Vaccine** *(Document dates of doses on page in box above)*

HUMAN PAPILLOMAVIRUS (HPV)

Dose 1: ____/____/____ M D Y Dose 2: ____/____/____ M D Y Dose 3: ____/____/____ M D Y

PNEUMOCOCCAL

____/____/____ M D Y Type Received: _____

SHINGLES VACCINE: Date: _____

	YES	*NO*	*WHEN*	
Scarlet Fever				
Measles				
German measles				
Mumps				
Chicken Pox				
Malaria				
Rheumatic Fever, Heart				
Blood Transfusion				
Surgery(ies)				***Type of:***
Frequent Depression				***Medication:***
Frequent Anxiety				***Medication:***
Other Medical Conditions?				

Are there any irregularities of the following systems? If yes please describe.

	Normal	Abnormal
Head, ears, nose or throat		
Eyes		
Respiratory		
Cardiovascular		
Gastrointestinal		
Genitourinary		
Musculoskeletal		
Endocrine		
Neuropsychiatric		
Skin		
Teeth		
Allergies to Medication, Food, Other:		

Recommendations for physical activity: Unlimited or Limited:_____

Current Medications:_____

Is the patient now under treatment for any medical or emotional condition? Yes No

Do you have any recommendations regarding the care of this student? Yes No. If "yes," what are they?

_____

Office Stamp **(Required)**

Physician's Name & Title: _____

Signature: _____

Date: _____ **Office Telephone: ( )** _____

STUDENT'S or APPLICANT'S PERMISSION FOR USE:

I, the undersigned, have freely and knowingly supplied all information contained in this document to Saint Vincent Seminary and/or Archabbey as part of my admissions procedure to either the seminary or the monastery. I grant full permission and access to the information contained in these documents to the administration, admissions staff, infirmary, College Health Center, medical staff, and to the Health Care administrator of both the Seminary and the Monastery for the purposes of my admissions procedures and for my personal healthcare, insurance, and medical needs. This permission remains in effect until such time that I revoke this authorization in writing to the above named recipients, except for that information which has already been released in accordance with the authorization prior to my revocation.

Signature: _____ ***Date:*** _____

Witness: _____ ***Date:*** _____

Pennsylvania State Law and Meningitis and Meningococcal Disease

The Pennsylvania College and University Student Vaccination Act, signed into law in June 2002, requires students living in campus housing in the state of Pennsylvania to be immunized against meningococcal disease or to sign a waiver that they have received detailed information on the risks associated with meningococcal disease and the availability and the effectiveness of vaccine and that they choose not to be vaccinated.

In accordance with this act Saint Vincent College and Seminary have implemented the following requirements. These requirements apply to all students living on campus, including students enrolled in campus-based residential summer programs. All students who will be living in campus housing and who are age 21 or younger ***must submit proof of 1 dose of meningococcal conjugate vaccine (M C V 4) that covers serogroups A, C, Y, and W-135 since age 16.*** Students are exempt from this requirement only if there is a medical contraindication to vaccination or if religious beliefs prohibit immunization. Requests for exemption must be accompanied by a signed waiver.

Students living on campus who are over age 21 may either submit proof of vaccination since age 16 or submit the Meningococcal Immunization Waiver in accordance with the College and University Student Vaccination Act. Due to the short time frame of summer-only residential programs, students enrolled in these programs must be in compliance prior to arrival on campus.

Those students who are not in compliance after arrival may obtain this immunization through the College Health Center or the Monastery Infirmary (for Monastery residents) at the student's expense.

Incoming students may request a medical or religious exemption. Requests must include a signed statement from an allopathic or osteopathic physician indicating why this vaccine is medically contraindicated. Requests for religious exemption must include a detailed written statement of personal religious beliefs or a letter from clergy. All requests must include a signed Meningococcal Immunization Waiver (see below).

Additional information about meningococcal disease and vaccine is available at:

- the American College Health Association (www.acha.org),
- Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/meningococcal/index.html
- Vaccine Information Statement at http://www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.html

SAINT VINCENT SEMINARY AND ARCHABBEY

INFORMATION ABOUT MENINGOCOCCAL DISEASE AND WAIVER FORM

Meningococcal disease is a rare but potentially fatal bacterial infection, expressed as either meningitis (infection of the membranes surrounding the brain and spinal cord) or meningococcemia (bacteria in the blood). Meningococcal disease strikes about 3,000 Americans each year and is responsible for about 300 deaths annually.

Approximately 100 to 125 cases of meningococcal disease occur annually on college campuses and five to 15 students die as a result. Serotypes C, Y and W-125 cause a majority of cases in college students (65 percent). Research has shown that students residing in dormitories appear to be at higher risk for meningococcal disease than college students overall. Further research shows freshmen living in dormitories have a six times higher risk of meningococcal disease than college students overall.

Meningococcal vaccine provides protection against the most common strains of the disease, including serogroups A, C, Y and W-135. ***The duration of protection is approximately three to five years***. The vaccine is very safe and adverse reactions are mild and infrequent, consisting primarily of redness and pain at the site of injection lasting up to two days.

The Advisory Committee on Immunization Practices (ACIP) of the U.S. Centers for Disease Control and Prevention (CDC) recommends that college freshmen (particularly those who live in dormitories or residence halls) be informed about meningococcal disease and the benefits of vaccination, and that students who wish to reduce their risk for meningococcal disease be immunized. Other undergraduate students who wish to reduce their risk for meningococcal disease may also choose to be vaccinated.

Under the terms of the College and University Student Vaccination Act of the state of Pennsylvania, students living in campus housing must be immunized against meningococcal disease or sign a waiver that they have received detailed information on the risks associated with meningococcal disease and the availability and the effectiveness of vaccine and that they choose not to be vaccinated.

All students who will be living in campus housing or the monastery and who are <u>age 21 or younger</u> must submit proof of 1 dose of meningococcal conjugate vaccine that covers serogroups A, C, Y, and W-135 since age 16. Incoming students living on campus who are <u>over age 21</u> may either submit proof of vaccination since age 16 or submit the Meningococcal Immunization Waiver in accordance with the College and University Student Vaccination Act.

WAIVER

I have read the above information about the risks of meningococcal disease and the benefits of immunization. I hereby attest that I am declining immunization at this time. ***Incoming students may waive this requirement <u>only if</u> there is a medical contraindication to vaccination or if religious beliefs prohibit immunization.***

Signature	Student name (printed)
Signature of parent (if under 18)	Parents name (if under 18) (printed)
Student number	Date