From the Health Services Office

Welcome to Moore College of Art & Design. Health Services is located on the first floor of Stahl Hall. Diane Azuma, Moore's Registered Nurse, is available during the fall and spring semesters to meet students' routine health care needs and to handle emergencies. Health Services is open Monday through Friday from 9am-3pm. (summer 9am-2pm)

Counseling Services
In addition to your coverage for your physical needs, Student Affairs also has a mental health counselor: Laura Farrell, LSW. The counselor has hours Monday – Friday, The counselor can also make referrals to off-campus therapists or psychiatrists and handle psychological emergencies in conjunction with other relevant staff members or administration. (Fall+ Spring Semester Only) MOORE also offers virtual counseling services to all students by HEALTHIEST YOU. Contact Student Affairs for further information.(Fall + Spring semesters only)

Health Insurance
Moore requires that all undergraduate students have health insurance. If you are insured under your family's health plan, you will need to submit documentation of coverage. The link to the health insurance waiver will be made available via Moodle on the New Student Guide. For students without coverage, you will need to purchase Moore's insurance. **Note, if you do not fill out the waiver or opt-out form, you will be automatically enrolled in Moore's insurance.**
(Fall + Spring Semester Students Only)

Health Form
Enclosed in this letter is the Health Form. It is your responsibility to have this form completed, signed by your physician, and returned to the health services office. **You must see a doctor in order to fill out sections of this form**, so make sure to make an appointment as soon as possible. It can sometimes take several weeks or even a month to get an appointment.

What you need to include with the Health Form
In order to ensure that each section is thoroughly completed, you will find a checklist in the packet that outlines which sections you and your doctor must fill out. **You must also include the following and attach it to this form:**
-Your immunization record
-A copy (front and back) of your health insurance card

Due Dates
It is very important that you complete the health form and have it sent in by the dates listed below. The due date is contingent upon whether you live on or off campus. Failure to return a completed health form will result in a $100 penalty, and a hold will be placed on your student account.

- Incoming College Residents: Your health form is due **Monday, 7/17/2023.** Residents without completed health forms may not move into housing.
- Commuter Students: Your health form is due **Friday 9/8/2023**
- SADI Students: Your health form is due **Thursday 6/1/2023**

Finding a Physician
If you do not have a primary care doctor and need guidance, you may contact the Student Affairs Office (215-965-4040) and we can assist you in figuring out the steps to finding a doctor's office or clinic. All charges for your office visit are your responsibility. There is typically a fee for a visit, in addition to the charge for vaccinations or laboratory work you may require. You must bring previous vaccination records to the physician as well.

We are pleased to say that the college is well equipped to meet your health needs. We welcome you as an incoming student and look forward to helping you stay healthy while you pursue your education as an artist.

Sincerely,
Diane Azuma
Director of Health Services
Email: healthservices@moore.edu
Tel.: 215-965-4032 Fax: 215-564-1459

MORE COLLEGE OF ART & DESIGN

Health History and Immunization Form Checklist

Use this form as a checklist to make sure every section of this form is completed by you and your Health Care Provider. There are five sections of the form.

❑ **A. Section I: Health History—to be completed by the Student.**

This information is strictly for the use by Health Services Staff and will not be released to anyone. **All students must sign the bottom of Section I, verifying that the information is correct.**

*Note, if you are under the age of 18, your parent or guardian must sign directly below in the section labeled "Parental Permit."

❑ **B. Section II: List of Required vaccines and Recommended vaccines**

Please read through the listed vaccines. Your doctor will be required to fill out and verify in the next section. Also discuss with your health care provider the need for the additional four vaccines indicated on the bottom of the page.

❑ **C. Section III: Immunization Record—to be completed by a physician**

In addition to attaching an official copy of your immunization record, your physician must complete this section of the form. If you do not have a required vaccine, the record indicates the next steps your physician must take.

❑ **D. Section IV: Tuberculosis Screening—to be completed by you AND the Physician**

Your doctor should read over this section and circle either yes or no for each bullet point. If you circle yes to any of the questions, your doctor must conduct aTuberculin skinTest.

❑ **E. Section V: Tuberculosis Risk Assessment—to be completed by physician.**

If it is determined that you must receive aTB SkinTest, as indicated in Section IV, your doctor must go through the steps of filling out this form. The results of this test take several days to read; therefore you will need to bring back this section of the form when you return to the office for the results in order for this form to be completed.

❑ **F. Additional Reminders**

1. Make sure your Health Care Provider Signs and dates the form on page 7.
   It will not be complete until she/he does so.
   Do not forget to attach a copy of your current insurance plan as well as a copy of your immunization record.
2. Instructions for returning the form are provided on page 7.

MOORE COLLEGE OF ART & DESIGN

START DATE:_____ ❑ Undergraduate ❑ SADI ❑ Graduate ❑ Post Bacc.

SECTION I: TO BE FILLED OUT BY THE STUDENT

A health history must be completed by **ALL** students. This information is strictly for the use of the Student Health Services and will not be released to anyone without your knowledge or consent. **PLEASE COMPLETE AND RETURN DIRECTLY TO THE DIRECTOR OF HEALTH SERVICES.**

Legal Last name | Legal First Name | Middle Initial | Preferred Name | Moore Student ID number

Home address | City | State | Zip

Local address | City | State | Zip

Date of Birth | Marital Status | Class Entering | Home Telephone | Cell phone #

Emergency Contact Person | Home Telephone | Business Telephone

HEALTH INSURANCE INFORMATION: PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR HEALTH INSURANCE CARDS

PERSONAL HISTORY: Please answer all questions

Gastrointestinal:	Yes	No
Constipation	❑	❑
Recurrent diarrhea	❑	❑
Hemorroids	❑	❑
Ulcer	❑	❑
Frequent upset	❑	❑
stomach Heartburn	❑	❑
Irritable bowel	❑	❑
Jaundice	❑	❑
Gall bladder problem	❑	❑
Hernia	❑	❑
Other:	❑	❑

Genitourinary:	Yes	No
Kidney disease Bladder/ kidney infections	❑	❑
Kidney stones	❑	❑
Sexuallytransmitted infection Noperiod	❑	❑
Painfulperiods	❑	❑
Irregularperiods	❑	❑
Breastlump	❑	❑
Pelvicinfection	❑	❑
Pregnancies	❑	❑
Other:	❑	❑

Musculoskeletal:	Yes	No
Back problems	❑	❑
Arthritis	❑	❑
Strains/sprains	❑	❑
Neck injury	❑	❑
Other:	❑	❑

Skin:	Yes	No
Acne	❑	❑
Eczema	❑	❑
Psoriasis	❑	❑
Rashes	❑	❑
Other:	❑	❑

Head:	Yes	No
Eye problems	❑	❑
Glasses/Contacts	❑	❑
Ear infections	❑	❑
Hearing difficulty	❑	❑
Nose problems	❑	❑
Sinusitis	❑	❑
Throat problem	❑	❑
Other:		

Cardiovascular:	Yes	No
Murmur	❑	❑
High or low blood pressure	❑	❑
Anemia	❑	❑
Antibiotics prior to dental work	❑	❑
Palpitations	❑	❑
Chest pain	❑	❑
Blood clots	❑	❑
High cholesterol	❑	❑
Other:	❑	

Respiratory:	Yes	No
Asthma	❑	❑
Bronchitis	❑	❑
Pneumonia	❑	❑
Tuberculosis	❑	❑
Chronic cough	❑	❑
Shortness of breath	❑	❑
Other:		

Neurological:	Yes	No
Headache	❑	❑
Dizziness/fainting	❑	❑
Seizures	❑	❑
Weakness	❑	❑
Head injury/ concussion Paralysis	❑	❑
Loss of consciousness	❑	❑
Frequent anxiety	❑	❑
Frequent depression	❑	❑
Worry/nervousness	❑	❑
Other:	❑	❑

Metabolic/Endocrine:	Yes	No
Diabetes	❑	❑
Thyroid disorder	❑	❑
Other	❑	❑

Other:	Yes	No
Cancer	❑	❑
Anorexia / bulimia	❑	❑
Radiation/ chemotheraphy	❑	❑
Recent weight gain/loss	❑	❑
Do you drink alcohol?	❑	❑
Do you smoke?	❑	❑

Infectious Illnesses:	Yes	No
Chicken pox	❑	❑
Measles	❑	❑
Rubella-German measles Mumps	❑	❑
Mononucleosis	❑	❑
Hepatitis Type:	❑	❑
Rheumatic fever Other:	❑	❑

Last Name_____First Name_____DOB:_____/_____/_____

Do you take any medications? (ie:all drugs,including over the counter drugs,birth control pills,laxatives,sleeping medications,etc.) **Yes**_____**No**_____

If yes, pleaselist:_____

Please list Physician(s), Dentist, Opthamologist	**Telephone number**

	Yes	**No**	**If yes, please give details**
Are you allergic to any medications?	❑	❑	
Allergies (Food, insects, others)	❑	❑	
Have you had difficulty with school studies or teachers?	❑	❑	
Have you had an illness or injury or been hospitalized other than already noted?	❑	❑	
Have you received treatment or counseling for stress, nervous condition, personality or character disorder, or emotional problem?	❑	❑	

FAMILY HISTORY

Parents	**Age**	**State of Health**	**Occupation**	**Age of Death**	**Cause of Death**

TO BE SIGNED BY THE STUDENT (MUST BE SIGNED BY STUDENT OR FORM WILL NOT BE PROCESSED)

1. STUDENT STATEMENT

ALL STUDENTS: The information provided in this form is correct. I understand that failure to complete the form correctly may jeopardize my student standing at Moore College of Art & Design. I will return the form to the appropriate address at the end of this form.

Student Signature_____

Student ID #:

___ ___ ___ ___ ___ ___ ___ ___ ___

Signature of parent/guardian if student is a minor_____Date_____

PARENTAL PERMIT

The Law requires that parental permission be obtained for procedures on minors. The following consent form should be signed by the parents so that such procedures may be promptly carried out with no unnecessary delays. However, no major operation will be performed, except in extreme emergency, without parents being contacted and fully informed. I give permission for such diagnostic and therapeutic procedure as may be deemed necessary for my daughter and also to present information concerning her medical condition to other responsible college officials when deemed desirable.

Signature_____Relationship_____Date_____

MORE COLLEGE OF ART & DESIGN

SECTION II: List of Immunization Requirements

As a condition of enrollment, all full-time students and all students living in campus housing must meet the following requirements. Failure to meet these requirements will result in denial of student registration privileges.

1. Hepatitis B

Hepatitis B, recombinant (Engerix-B, Recombivax HB)

Hepatitis B recombinant, adjuvanted HepB-CpG (Heplisav-B)

- Hep B—series of 3 doses (given at 0, 1 and 6 mo. interval) for adults 18 and over; adolescents ages 11-15 years may receive 2 adult doses of Recombivax HB (given at 0 and 4-6 mo. interval) *
- Adjuvanted HepB-CpG—series of 2 doses (given at 0, 1 mo.); age 18 or older who are unvaccinated or incompletely vaccinated; must have minimum of 4 weeks interval and both doses HepB-CpG
- Blood test showing immunity

INTERCHANGEABILITY AND DOSING SCHEDULE:
Series consisting of a combination of 1 dose of adjuvanted HepB-CpG and Hep B):

- Adhere to the 3-dose schedule, minimum of 4 weeks between dose 1 & 2; 8 weeks between dose 2 & 3; and 16 weeks between dose 1 & 3.
- If HepB-CpG is substituted for dose 2 of Hep B, it is recommended that the HepB-CpG is the third dose (given a minimum of 4 weeks from the previous dose to complete the 3-dose series). **Combined hepatitis A and B vaccines may be given as a series of 3 doses (given at 0, 1-2, and 6-12 mo.) for 18 years of age and older.*

2. Measles, Mumps, Rubella (MMR)

- 2 doses of MMR vaccine are required. Dose 1 must be administered after the 1st birthday. Dose 2 must be administered at least 4 weeks after the 1st dose. OR
- Blood test showing immunity

3. Varicella (Chicken Pox)

- 2 doses of varicella (chicken pox) vaccine are required. They must be administered at least 4 weeks apart. OR
- Blood test showing immunity OR
- Physician documented history of chicken pox disease

4. Tetanus-Diphtheria-Pertussis (Tdap)

- **Booster doses:** For Adolescents 11-18 and adults 19-64: Single dose Tdap. Tdap can be administered regardless of interval since the last tetanus or diphtheria toroid-containing vaccine.
- **Routine booster dose intervals:** Adults should receive tetanus booster at 10-year intervals, beginning 10 years after receiving Tdap. Subsequently, either Tdap or Td may be used for booster doses.

5. Meningococcal

1. 1 dose of meningococcal conjugate vaccine (MCV4, such as Menactra or Menveo) administered since age 16 is required of all incoming students who are age 21 or younger.
    - At minimum, serogroups A, C, Y, and W-135 must be covered.
2. Incoming students living on campus who are age 22 or older may submit either proof of vaccination or a Meningococcal Vaccine Waiver.
3. www.cdc.gov/meningococcal

6. Polio Vaccine

- Inactivated (IPV)
- Oral poliovirus (OPV no longer available in U.S.)

VACCINATION SCHEDULE: Primary series in childhood with IPV alone, OPV alone, or IPV/OPV sequentially; IPV booster only if needed for travel after age 18 years.

7. Tuberculosis

- Screening and risk assessment required. Please discuss with healthcare provider.

MORE COLLEGE OF ART & DESIGN

SECTION II: List of Immunization Requirements

As a condition of enrollment, all full-time students and all students living in campus housing must meet the following requirements. Failure to meet these requirements will result in denial of student registration privileges.

Please discuss the need for the following vaccines with your healthcare provider.

8. COVID19
Vaccination Type:_____Date/s_____Booster Date:_____

9. Influenza: Annually

- Quadrivalent (IIV4, ccIIV4)_____Live attenuated influenza vaccine (LAIV) _____
- Recombinant influenza Vaccine RIV4 _____

10. Quadrivalent Human Papillomavirus Vaccine (HPV2, HPV4 or HPV9)

11.Pneumococcal Polysaccharide Vaccine

(One dose for members of high-risk groups)

12. Meningococcal Serougroup B
(Two or three dose series; may be given to any college student)

MORE COLLEGE OF ART & DESIGN

THIS FORM IS DUE **Monday, July 17, 2023** (Incoming Residents)
THIS FORM IS DUE **Friday, September 8, 2023** (Commuter Students)
THIS FORM IS DUE **Thursday, June 1st, 2023** (SADI)

SECTION III: IMMUNIZATION RECORD

PART 1: COMPLETED BY THE STUDENT.
ALL INFORMATION MUST BE PRINTED LEGIBLY OR FORM CANNOT BE PROCESSED.

Last Name:_____First Name:_____Middle Initial:_____DOB:_____/_____/_____

Date of Entry:_____Student ID #: _____

Full Mailing Address:
StreetAddress_____City_____State_____ZIP Code _____

Please Check: ___Resident ___Commuter Please Check: ___Undergraduate___SADI ___Graduate ___Post Bacc.

Hepatitis B
Heplisav-B (2 dose series) is not interchangeable with other hepatitis B vaccines (3 dose series) but can substituted for dose #2 and #3
Adult Formulation_____Child Formulation_____HepB-CpG (Heplisav-B)_____

2.Immunization (Combined hepatitis A and B vaccine)
a.Dose #1____/____/_____b. Dose #2____/____/_____

3. Quantitative Hepatitis B surface antibody (recommended for individuals born in or whose mother was born in a hepatitis B endemic country, and/or men who have sex with men).
Date ____/____/_____Result: Reactive_____Non-reactive _____

Dose 1 ___/___/___ Month DayYear

Dose 2 ___/___/___ Month DayYear

Dose 3 ___/___/___ Month DayYear

Measles, Mumps, Rubella
2 doses of vaccine or a blood test showing immunity.

Measles Antibody month_____yr._____
result: positive_____negative_____

Mumps Antibody month_____yr._____
result: positive_____negative_____

Rubella Antibody month_____yr. _____
result: positive_____negative_____

MMR Dose 1 ___/___/___ MonthDayYear

OR

Measles Dose 1 ___/___/___ Month DayYear

Mumps Dose 1 ___/___/___ Month DayYear

Rubella Dose 1 ___/___/___ Month DayYear

MMR Dose 2 ___/___/___ Month DayYear

Measles Dose 2 ___/___/___ Month DayYear

Mumps Dose 2 ___/___/___ Month DayYear

Rubella Dose 2 ___/___/___ Month DayYear

Meningococcal (serogroups A, C, Y, and W-135)
1 dose since age 16 for all incoming students who are age 21 or younger.
- MenACWY-CRM (Menveo)
- MenACWY-D (Menactra)
- MenACWY-TT (MenQuadfi)

Vaccine Schedule:
- Initial Dose:11-12 years of age
- Booster Dose: 16 years of age

Meningococcal Initial Dose ___/___/___ Month DayYear

Meningococcal Booster Dose ___/___/___ Month DayYear

Please specify vaccine type: ___

(such as Menactra, Mencevax, Menveo) **or MenQuadfi:**_____

Tetanus-Diphtheria and Pertussis (Tdap)
Td (tetanus- diphtheria) does not satisfy this requirement.
Booster doses: For Adolescents 11-18 and adults 19-64: Single dose Tdap. Tdap can be administered regardless of interval since the last tetanus or diphtheria toroid-containing vaccine.
Routine booster dose intervals: Adults should receive tetanus booster at 10-year intervals, beginning 10 years after receiving Tdap. Subsequently, either Tdap or Td may be used for booster doses.

Tdap ___/___/___ Month DayYear

Td ___/___/___ Month DayYear

Varicella (Chicken Pox)
2 doses of vaccine ***or*** history of illness, ***or*** a blood test showing immunity.

Dose 1 ___/___/___ Month DayYear

Dose 2 ___/___/___ Month DayYear

OR

Varicella Illness ___/___/___ Month DayYear

Varicella antibody month_____yr._____
result: positive_____negative_____

Polio
1. OPV alone (oral Sabin three doses): #1 ____/____/____ Month Day Year **#2** ____/____/_____ Month Day Year **#3** ____/____/_____ Month Day Year

2. IPV/OPV sequential: IPV #1 ____/____/_____ Month Day Year **IPV #2** ____/____/_____ Month Day Year **OPV #3** ____/____/_____ Month Day Year **OPV #4** ____/____/_____ Month Day Year

3. IPV alone (injected Salk four doses): #1 ____/____/_____ Month Day Year **#2** ____/____/_____ Month Day Year **#3** ____/____/_____ Month Day Year **#4** ____/____/_____ Month Day Year

Covid19

Vaccination Type:_____Primary Series: Dose 1:_____Dose 2: _____Booster:_____

Section IV: To be completed by Student and Physician.

Last Name _____ **First Name** _____ **DOB** _____

TUBERCULOSIS (TB) SCREENING/TESTING

Please answer the following questions:

1. Have you ever had close contact with persons known or suspected to have activeTB disease? ❑ Yes ❑ No

2. Were you born in one of the countries listed below that have a high incidence of activeTB disease?(If yes, please CIRCLE the country, below) ❑ Yes ❑ No

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2020. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/

3. Have you had frequent or prolonged visits* to one or more of the countries listed above with a high prevalence of TB disease?(If yes, CHECK the countries, above) ❑ Yes ❑ No

4. Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ❑ Yes ❑ No

5. Have you been a volunteer or health-care worker who served clients who are at increased risk for activeTB disease? ❑ Yes ❑ No

6. Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or activeTB disease .– medically underserved, low-income, or abusing drugs or alcohol? ❑ Yes ❑ No

If the answer is YES to any of the above questions, Moore College of Art & Design requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester.

If the answer to all of the above questions is NO, no further testing required.

**The significance of the travel exposure should be discussed with a health care provider and evaluated.*

SECTION V: Clinical Assessment by Health Care Provider

Clinicians should review and verify the information in Part I. Persons answering YES to any of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below) Yes_____No _____

History of BCG vaccination? (If yes, consider IGRA if possible.) Yes_____No _____

1. TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes / No If No, proceed to 2 or 3

If yes, check below:

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

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Interferon Gamma Release Assay (IGRA)

Date Obtained:_____/____/____ (specify method) QFT-GIT T-Spot other_____
M D Y

Result: negative____ positive____ indeterminate____ borderline____(T-Spot only)

Date Obtained:_____/____/____ (specify method) QFT-GIT T-Spot other_____
M D Y

Result: negative____ positive____ indeterminate____ borderline____(T-Spot only)

3. Tuberculin Skin Test (TST)
(TST result 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:_____/____/____
M / D / Y

Result:_____mm of induration

Date Read:_____/_____/_____
M / D / Y

**Interpretation: positive_____negative_____

Date Given:_____/____/____
M / D / Y

Result:_____mm of induration

Date Read:_____/____/____
M / D / Y

**Interpretation: positive_____negative _____

**Interpretation guidelines

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

>10 mm is positive:

- Foreign born or travelers to the US from High Prevalence areas or who resided in one for a significant *amount of time.
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight. .

>15 mm is positive:

- persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

* The significance of the travel exposure should be discussed with a health care provider and evaluated.

4. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray:____/____/____ Result: normal____abnormal____
M / D / Y

Part III. 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. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- ❑ Infected with HIV
- ❑ Recently infected with M. tuberculosis (within the past 2 years)
- ❑ History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- ❑ Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- ❑ Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- ❑ Have had a gastrectomy or jejunoileal bypass
- ❑ Weigh less than 90% of their ideal body weight
- ❑ Cigarette smokers and persons who abuse drugs and/or alcohol

_____Student agrees to receive treatment Student

_____declines treatment at this time

_____ _____
Health Care Professional Signature Date

How to Return Your Health Form & Immunization Record:

Please upload your health form and immunization record ***to your Moore student portal.***

- PDF files work best, if possible. Free scan apps for your phone are available and helpful.
- Photos are acceptable, if they are clear, legible, and easy to read.