UNDERWOOD UNIVERSITY

STUDENT IMMUNIZATION RECORD (FORM I)

(Return this form to Underwood University when completed)

Name: _____ Student ID #: _____

Address: _____

Phone: _____ Email: _____

Semester and year of application (e.g. Spring 2018): _____

Degree program: _____ Date of birth (mm/dd/yyyy): _____

REQUIRED IMMUNIZATION INFORMATION

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY	HISTORY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE
MMR[1]	/ /	/ /			
Measles[1]	/ /	/ /			/ /
Mumps[1]	/ /	/ /			/ /
Rubella[1]	/ /	/ /			/ /
Varicella[3]	/ /	/ /		(or history of Varicella) / /	
Tetanus-Diphtheria Pertussis (Whooping Cough)[4]	/ / Tdap	/ / Td Booster[4]			
Hepatitis B[2]	/ /	/ /	/ /	Type Series: ( ) 2 Dose Series ( ) 3 Dose Series	/ /

1—Not required if born before1957.

2—Only required of students who are 18 years of age or younger at time of expected matriculation.

3—Required for all US born students born in 1980 or later; and all foreign-born students regardless of year born.

4 – Td booster only necessary if > 10 years since Tdap dose.

PERMANENT OR TEMPORARY IMMUNIZATION EXEMPTION

( ) This student is exempt from the above immunizations on the grounds of permanent medical contraindication.

( ) This student is temporarily exempt from the above immunizations until (mm/dd/yyyy): _____

CERTIFICATION OF HEALTH CARE PROVIDER

Name and signature: _____

Address:_____

Date of Issue: _____

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NON-MEDICAL EXEMPTIONS

Check the appropriate box, sign, and date if you are claiming exemption from immunization requirement for one of the following reasons:

( ) I hereby affirm that immunization as required by university systems of Georgia is in conflict with my religious beliefs. I understand that I am subject to exclusion in event of an outbreak for which immunization is required.

Signature: _____ Date: _____

( ) I declare that I will be enrolling ONLY in courses offered via distance learning. I understand that if I register for a course that is offered on-campus or at a campus managed facility, this exemption becomes void and I will be excluded from class until I provide proof of immunizations.

Signature: _____ Date: _____

RECOMMENDED IMMUNIZATION INFORMATION (NOT REQUIRED)

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY	HISTORY	DATE OF POSITIVE LAB/ SEROLOGIC EVIDENCE
Human Papillomavirus[5]	/ /	/ /	/ /		
Hepatitis A[6]	/ /	/ /	/ /	Type Series: ____ 2 Dose Series ____ 3 Dose Series	/ /
Meningococcal ACWY [7, 8] (MCV4)	/ /	/ / MCV4 Booster[8]			
Meningococcal B[9]	/ /	/ /	/ /	Type Series: ____ 2 Dose Series ____ 3 Dose Series	
Annual Influenza [6]	/ /	/ /			

5 – Strongly recommended for all unvaccinated males and females through age 26 years.

6 - Strongly recommended but not required.

7 - Strongly recommended if residing in campus housing, sorority housing, or fraternity housing.

8 - MCV4 Booster necessary if initial MCV4 dose was received more than 5 years prior to admittance.

9 - Consider if younger than 23 yrs. of age.

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APPLICANTS WHO HAVE NOT PREVIOUSLY ATTENDED UNDERWOOD UNIVERSITY MUST SUBMIT PROOF OF ALL REQUIRED IMMUNIZATIONS, CERTIFIED BY A HEALTH OFFICIAL

The Board of Regents and the Division of Public Health of the Georgia Department of Human Resources have developed the requirements and recommendations outlined in the tables below. Applicants must submit **one** of the following documents in order to provide proof of required immunizations. **No other documentation will be accepted.**

* GA County Health department Immunization History
* UU certificate of Immunization
* GA Department of Human Resources Certificate of Immunization
*World Health Organization Certificate of Immunization

VACCINE	REQUIREMENT	REQUIRED FOR:
Measles (Rubeola)	Two doses of live measles Vaccine (Combined measles-mumps-rubella (MMR) meets this requirement), with first dose at 12months of age or later and second dose at least 28 days after the first dose or laboratory/serologic evidence of immunity	Students born in 1957 or later
Mumps	One dose at 12months of age or later. MMR meets this requirement, as does laboratory/serologic evidence of immunity	Students born in 1957 or later
Rubella (German Measles)	One dose at 12months of age or later. MMR meets this requirement; as does laboratory/serologic evidence of immunity	Students born in 1957 or later
Varicella (Chicken Pox)	One dose given at 12months of age or later but before the student's 13th birthday, **OR** If first dose was given after the student's 13th birthday: Two doses at least 4 weeks apart or reliable history of varicella disease or laboratory/serologic evidence of immunity	All students
Tetanus, Diphtheria	One TD booster dose within 10 years prior to matriculation *Recommendation: Students who are unable to document a primary series of three doses of tetanus-containing vaccine DtaP, DTP, or Td) are strongly advised to complete athree-dose primary series with Td.*	All students
Hepatitis B	Three dose hepatitis B series (0, 1-2, and 4-6 months) **OR** Three doses combined hepatitis A and hepatitis B series (0,1-2, and 6-12 months) **OR** Two dose Hepatitis B series of Recomb Ivax (0 and 4-6months or at 11-15 years of age) or laboratory/serologic evidence of immunity or prior infection	**Required** for all students who will be 18years of age or less at time of expected matriculation. ***Recommendation: It is strongly recommended that all students, regardless of their age at matriculation, discuss Hepatitis B immunization with their healthcare provider.***

ADDITIONAL RECOMMENDED IMMUNIZATIONS (NOT REQUIRED)

- Meningococcal quadrivalent polysaccharide: one dose within 5 years prior to matriculation
- Influenza: Annual vaccination at the start of influenza season (October – March)
- Hepatitis A: two-dose Hep A series at 0 and 6 months; or three-dose combined Hep B series at 0, 1-2 months, and 6-12 months
- Other vaccines may be recommended for students with underlying medical conditions and students planning international travel. Students meeting these criteria should consult with their physicians or health clinic regarding additional vaccine recommendations.

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TUBERCULOSIS SCREENING (REQUIRED)

INSTRUCTIONS TO HEALTH CARE PROVIDER

Please review the below questions with the student and determine if he or she is at high risk for TB. Indicate the status below. If yes and you are within the United State of America, please complete a TB skin test on the student and complete page 2 of this form.

The following questions are designed to enable a physician or registered nurse to assess the risk of tuberculosis exposure. Answering "Yes" to any of these may indicate high risk of TB exposure, and a TB Skin Test is required.

Have you ever had a positive TB Skin test? Y / N

Have you ever lived, worked or volunteered in any of the following;

Homeless shelter	Y / N
Prison	Y / N
Long-time care facility	Y / N
Nursing home	Y / N
Rehabilitation facilities	Y / N

Have you ever known or come into contact with a person who has tuberculosis? Y / N

CURRENT SYMPTOMS RISK

Do you currently have any of following symptoms?

Persistent cough lasting two weeks or longer	Y / N
Fever or chills	Y / N
Loss of appetite or unexplained weight loss	Y / N
Persistent night sweats	Y / N

CERTIFICATION

In your professional opinion, is this student at HIGH RISK for TB exposure? Y / N
(If "Yes," please complete page 2 of this form)

Health care provider (name and signature): _____

Address: _____

Phone: _____ Date of Interview: _____

Student name and signature: _____

Date: _____

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TUBERCULOSIS SKIN TESTING FORM

Student name: _____ Student ID #: _____

Address: _____

Phone: _____ Email: _____

Date of birth: _____

A. Tuberculosis Skin Test

Date placed: _____ Date read: _____ (must be within 72 hours)

Result: _____ mm (record actual mm of induration, transverse diameter. If no induration, record as "0mm")

Final Interpretation (circle one): **POSITIVE** **NEGATIVE**

B. Chest X-Ray

Date of Chest x-ray: _____

Result (circle one): **NORMAL** **ABNORMAL***

***** a result of "Abnormal" requires a copy of the chest x-ray report in English and signed by a physician

C. Treatment

Has the student received anti-tubercular Drugs? Y / N

If "Yes," indicate type of treatment: _____

Duration of treatment: From (date) _____ to (date)_____

CERTIFICATION OF HEALTH CARE PROVIDER

Name and signature: _____

Address: _____

Date: _____ Phone: _____

Student's name and signature: _____

Date: _____

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