



Immunization Form

For Non Health Science Programs (Business, Graduate, Law, Public Health, Theology and Undergraduate)

Last Name: First Name: MI:
Emory Student ID #: Date of Birth: ___/___/___

If you are a School of Nursing, School of Medicine, or Allied Health student, please use the HEALTH SCIENCES immunization form.

- All incoming Emory students must meet the CDC and American College Health Association immunization guidelines.
Use of this form is required for documentation of compliance with Emory's immunization requirements.
ALL VACCINATIONS AND ANY NEEDED LAB WORK ARE TO BE COMPLETED PRIOR TO MATRICULATION.
Attach copy refers to a copy of the actual laboratory or x-ray report.
BE SURE YOUR HEALTHCARE PROVIDER SIGNS THE FINAL PAGE OF THIS FORM.

For more information about the required immunizations listed below, please visit our web site at: www.studenthealth.emory.edu/hs/new.students/immunization.

Required Vaccinations

MMR (Measles, Mumps Rubella) -- 2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps, and one (1) dose of Rubella; or provide lab report for positive Measles, Mumps, and/or Rubella antibody (titer)

Table with columns: Option, Vaccine, Dates. Rows include MMR, Measles, Mumps, and Rubella options with fields for vaccine names, serologic immunity, and dates.

Hepatitis B Vaccination -- 3 doses of vaccine OR provide lab report for positive QUANTITATIVE Hepatitis B Surface Antibody (titer).

Primary Hepatitis B Series: Dose #1, Dose #2, Dose #3
Serologic Immunity (IgG antibodies, titer): Date, Result mIU/ml, Attach copy checkbox

Tetanus-Diphtheria-Pertussis (Tdap) -- All students must have the basic primary series of 3 doses of Diphtheria-Tetanus Toxoid (DTP or DTaP). In addition, students must have one (1) adult Tdap. If Tdap is more than 10 years old, provide date of both the Tdap and the most recent Td (adult tetanus/diphtheria).

Tdap vaccine Date: Td vaccine Date

Varicella (Chicken Pox) Requirement: 2 doses of vaccine or provide lab report for positive varicella antibody (titer)

Varicella Dose #1 Date, Varicella Dose #2 Date, Serologic Immunity (IgG antibodies, titer), Attach copy checkbox

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Vaccinations Recommended but not Required

Polio Immunization

Completed primary series of polio immunization. Type: Oral ___ Inactivated ___ Completion Date: ___/___/___

Meningococcal Immunization: **Meningitis ACWY Vaccination:** Date of last dose: ___/___/___

Meningococcal B Vaccination: Indicate which brand. Trumenba ___ Bexsero ___

MenB Dates: Dose #1 ___/___/___ Dose #2 ___/___/___ Dose #3 (if applicable) ___/___/___

HPV (Human Papillomavirus) Indicate which preparation, if known. HPV2 ___ HPV4 ___ HPV9 ___

Dates: Dose #1 ___/___/___ Dose #2 ___/___/___ Dose #3 ___/___/___

Other vaccinations, such as hepatitis A, BCG, pneumococcal, rabies, typhoid, yellow fever (include month, day, year) :

Tuberculosis (TB) Screening Requirement (Sections A and B to be completed by student)

Section A: History of TB?

1. Have you ever had a positive TB screening test? This can include skin test (PPD/TST) or blood test (Quantiferon Gold or T-spot).	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Section B: At risk for TB?

2. Have you ever had close contact with persons known or suspected to have active TB disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Were you born in one of the countries or territories listed on page 4 that have a high prevalence of TB disease? If so, list country: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you had frequent or prolonged visits* to one or more of the countries or territories listed on page 3 with a high prevalence of TB disease? If so, list countr(ies): _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Have you ever been a member of any of the following groups that may have an increased incidence of latent <i>M. tuberculosis</i> infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Student signature _____

Date: ___/___/___

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

If the answer is YES to any of the above questions, Emory University requires that you receive TB testing as soon as possible within the six months prior to the start of your first semester. **(See next page)**

If the answer is NO to all of the above questions, no further testing or further action is required. Go to page 3 for health care provider signature.

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TUBERCULOSIS SCREENING, CONTINUED

Section C: To be completed by health care provider if YES to any questions in Sections A or B.

Clinicians should review and verify the information in Sections A and B. If the patient answered **NO** to all questions, **no further testing is required; proceed to signature section below.**

If the patient answered **YES** to any questions, a tuberculin skin test (TST) and/or blood test is **REQUIRED**. History of BCG vaccination does not preclude the testing requirement. An IGRA blood test is preferred with history of BCG.

If PPD and/or TB blood test is positive, chest x-ray is **REQUIRED**.

Copies of lab reports and radiology reports are required if tests are performed.

Tuberculin Skin Test (TST) - must include date of placement, date of reading, and # of mm of induration, even if zero.

Date Placed: ___/___/___ Date read: ___/___/___

Result: ___ mm of induration Interpretation: Positive Negative

Interferon Gamma Release Assay (IGRA):

Date obtained: ___/___/___ Specify test: T-spot Quantiferon Gold

Negative Positive Indeterminate Borderline Attach copy

Chest x-ray -- *required if TST or IGRA is positive*

Date of Chest x-ray: ___/___/___ Result: Normal/Negative Abnormal Attach copy

TB Prophylaxis -- *If diagnosed with latent TB did patient complete a course of medication?* Yes No

If yes, medication(s): _____ When? _____ Number of months: _____

FORM MUST BE COMPLETED AND SIGNED BY YOUR HEALTHCARE PROVIDER

Authorized Signature: _____ **Date:** ___/___/___

Printed Name and Title: _____

Address: _____

City / State / Zip/Phone: _____

For verification of your immunization information, two steps are required:

- **Step 1:** Please **enter the information on this form electronically into your Patient Portal** at

<https://www.shspnc.emory.edu>.

- **Step 2:** Please **submit a copy of this form**. Ensure that all sections and signatures have been completed and that you have met all applicable Emory University immunization requirements.

Submitting the form:

- Upload a PDF version of the form through your Patient Portal at <https://www.shspnc.emory.edu>. **(PREFERRED METHOD)**

- Scan and email to immunizations-shs@emory.edu. We advise you to use your emory.edu email address (e.g., lord.dooley@emory.edu)

- Fax to 404-727-7343

- Mail to: Emory University Student Health Services, ATTN: Immunization Department, 1525 Clifton Road NE, Atlanta, Georgia, 30322

Thank you!

Countries and Territories with High Incidence of Active Tuberculosis Disease

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to <http://www.who.int/tb/country/en/>.

Secondary source: ACHA guidelines, Tuberculosis Screening and Targeted Testing of College and University Students, May 2017

HBC lists (TB, TB/HIV, MDR-TB) 2016-2020 published for WHO are included in this document