EMORY UNIVERSITY | Student Health Services
Campus Life

1525 Clifton Road NE
Atlanta, Georgia 30322
Phone # 404-727-7551
Fax # 404-727-7343

Immunization Form

For Health Sciences Programs (School of Medicine, Allied Health, and School of Nursing)

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

Please select your degree program (circle one): **AA** **DPT** **Genetic Couns** **Med Imaging** **MD** **Nursing** **PA**

- 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.** (Due dates to be determined by each degree program.) If necessary, multi-dose vaccination series started prior to arrival at Emory can be completed at EUSHS.
- **"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)*

Option 1	**Vaccine**	**Dates**
MMR -- *2 doses of MMR vaccine*	MMR	Dose #1 ___/___/_____ Dose #2 ___/___/_____
Option 2	**Vaccine or Test**	
Measles--*2 doses of vaccine or positive serology*	Measles	Dose #1 ___/___/_____ Dose #2 ___/___/_____
	Serologic Immunity (IgG antibodies/titer)	___/____/_____ ☐ Attach copy
Mumps--*2 doses of vaccine or positive serology*	Mumps	Dose #1 ___/___/_____ Dose #2 ___/___/_____
	Serologic Immunity (IgG antibodies/titer)	___/____/_____ ☐ Attach copy
Rubella--*1 dose of vaccine or positive serology*	Rubella	___/___/_____
	Serologic Immunity (IgG antibodies/titer)	___/___/_____ ☐ Attach copy

Hepatitis B Vaccination *-- 3 doses of vaccine followed by a 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
Secondary Hepatitis B Series (if nonimmune after primary series)	Dose #1 ___/___/_____ Dose #2 ____/____/_____ Dose #3 ____/____/_____		
Repeat Serologic Immunity (IgG antibodies/titer) after additional vaccine	Date: ____/____/_____	Result ____mIU/ml	☐ Attach copy
Hepatitis B Vaccine Non-responder (if Hep B surface antibody neg after primary & secondary series)	Hepatitis B Surface Antigen	___/___/_____	☐ Attach copy
	Hepatitis B Core Antibody	___/___/_____	☐ Attach copy
Chronic Active Hepatitis B	Hepatitis B Surface Antigen	___/___/_____	☐ Attach copy
	Hepatitis B Viral Load	___/___/_____	☐ Attach copy

Immunization Form, Emory School of Medicine, Allied Health, and School of Nursing

Last Name	First Name	Emory ID

Tetanus-Diphtheria-Pertussis (Tdap) *-- All students must have the primary series of Diphtheria-Tetanus-Pertussis vaccine (DTP or DTaP). In addition,* ***all students must have had one (1) adult Tdap*** *. If last Tdap is more than 10 years old, provide dates of last Td and Tdap.*

	Vaccine	Date	Vaccine	Date
	☐ Tdap Vaccine	___/___/_____	☐ Td Vaccine	___/___/_____

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

	Vaccine	Date	Vaccine	Date
	Varicella Dose #1	___/___/_____	Varicella Dose #2	___/___/_____
	Serologic Immunity (IgG antibodies, titer)		___/___/_____	☐ Attach copy
Influenza *-- required for entrance between September and April, inclusive*			___/___/_____	

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, pneumococcal, typhoid, yellow fever, rabies *(include month, day, year)* :

_____

Tuberculosis Screening -- Required

- Emory Schools of Medicine (SOM), Nursing (SON) and Allied Health (AH) require Tuberculosis (TB) screening (the first of a two-step PPD skin test, a chest x-ray, or an IGRA blood test) within 6 months prior to matriculation.

- For SON, both PPDs must be completed prior to matriculation.
- For SOM and AH, the second PPD will be administered after matriculation.
- For SOM and AH, **PPDs are used for annual TB clearance** unless a medical reason, such as history of BCG vaccine or prior positive TB test, exists.
- **IGRA blood test** is preferred **only** if you have ever received BCG vaccine or had a positive PPD.
- For SOM and AH students who do not have a medical reason as above for IGRA to be used, the first of a two-step PPD before arrival is preferred over IGRA to place class members on the same annual TB screening schedule. Otherwise a student may need to start a two-step PPD upon arrival.
- If you have a history of a positive PPD ≥10mm or positive IGRA, please complete Section B as fully as possible.
- **You only need to complete ONE section.**
- Emory's guidelines are based upon the recommendations of the CDC and the American College Health Association.

Section A		Date Placed	Date Read	Reading
Negative Skin Test, Blood Test, or Chest X-ray*	**PPD #1**	___/___/_____	___/___/_____	_____ mm
	PPD #2	___/___/_____	___/___/_____	_____ mm
	IGRA Blood Test ☐ T-Spot ☐ Quantiferon Gold		**Date** ___/___/_____	☐ Attach copy
	Chest X-ray	**Date** ___/___/_____		☐ Attach copy

 Please continue TB screening on page 3

Immunization Form, Emory School of Medicine, Allied Health, and School of Nursing

Last Name	First Name	Emory ID

TUBERCULOSIS SCREENING, CONTINUED

Section B		**Date Placed**	**Date Read**	**Reading**
History of Latent Tuberculosis, Positive Skin Test, or Positive Blood Test	Positive PPD	___/___/_____	___/___/_____	_____ mm
	Postive IGRA Blood Test	**Date** ___/___/_____	**Type test** ☐ T-Spot ☐ Quantiferon Gold	☐ Attach copy
	Chest X-ray	___/___/_____		☐ Attach copy
	Prophylactic medications for latent TB taken?		☐ Yes ☐ No	
	Start date and duration of prophylaxis		___/___/_____	_____ months
	Date of last annual TB symptom review with a healthcare provider (if applicable)		___/___/_____	
Section C				
History of Active Tuberculosis	Date of Diagnosis		___/___/_____	
	Date Treatment Completed		___/___/_____	☐ Attach copy
	Date of last annual TB symptom review with a healthcare provider (if applicable)		___/___/_____	
	Date of last Chest X-ray		___/___/_____	☐ Attach copy

FORM MUST BE COMPLETED AND SIGNED BY YOUR HEATHCARE PROVIDER

Authorized Signature:		Date: ___ / ___ / _____
Printed Name and Title:		
Address Line 1:		
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!