



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				
<ul style="list-style-type: none"> 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. <p>For more information about the required immunizations listed below, please visit our web site at: www.studenthealth.emory.edu/hs/new.students/immunization.</p>				
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)	__/__/__ <input type="checkbox"/> Attach copy		
Mumps--2 doses of vaccine or positive serology	Mumps	Dose #1 __/__/__ Dose #2 __/__/__		
	Serologic Immunity (IgG antibodies/titer)	__/__/__ <input type="checkbox"/> Attach copy		
Rubella--1 dose of vaccine or positive serology	Rubella	__/__/__		
	Serologic Immunity (IgG antibodies/titer)	__/__/__ <input type="checkbox"/> Attach copy		
Hepatitis B Vaccination -- 3 doses of vaccine followed by a positive <u>QUANTITATIVE</u> Hepatitis B Surface Antibody (titer)				
Primary Hepatitis B Series	Dose #1 __/__/__ Dose #2 __/__/__ Dose #3 __/__/__			
Serologic Immunity (IgG antibodies/titer)	Date: __/__/__	Result __ mIU/ml	<input type="checkbox"/> 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	<input type="checkbox"/> Attach copy	
Hepatitis B Vaccine Non-responder (if Hep B surface antibody neg after primary & secondary series)	Hepatitis B Surface Antigen	__/__/__	<input type="checkbox"/> Attach copy	
	Hepatitis B Core Antibody	__/__/__	<input type="checkbox"/> Attach copy	
Chronic Active Hepatitis B	Hepatitis B Surface Antigen	__/__/__	<input type="checkbox"/> Attach copy	
	Hepatitis B Viral Load	__/__/__	<input type="checkbox"/> Attach copy	

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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
	<input type="checkbox"/> Tdap Vaccine	___/___/___	<input type="checkbox"/> 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)		___/___/___	<input type="checkbox"/> 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		Date		<input type="checkbox"/> Attach copy
	<input type="checkbox"/> T-Spot <input type="checkbox"/> Quantiferon Gold	___/___/___			
Chest X-ray	Date ___/___/___		<input type="checkbox"/> Attach copy		

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TUBERCULOSIS SCREENING, CONTINUED

Section B	Date Placed	Date Read	Reading	
History of Latent Tuberculosis, Positive Skin Test, or Positive Blood Test	Positive PPD	_/_/____	_/_/____ ____ mm	
	Positive IGRA Blood Test	_/_/____	Date	
			Type test	
			<input type="checkbox"/> T-Spot	<input type="checkbox"/> Attach copy
			<input type="checkbox"/> Quantiferon Gold	
	Chest X-ray	_/_/____	<input type="checkbox"/> Attach copy	
	Prophylactic medications for latent TB taken?		<input type="checkbox"/> Yes <input type="checkbox"/> 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	_/_/____	<input type="checkbox"/> Attach copy
	Date of last annual TB symptom review with a healthcare provider (if applicable)	_/_/____	
	Date of last Chest X-ray	_/_/____	<input type="checkbox"/> Attach copy

FORM MUST BE COMPLETED AND SIGNED BY YOUR HEALTHCARE 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!