STUDENT IMMUNIZATION RECORD – NON-HEALTH SCIENCES

(If you are a Medical, Allied Health or Nursing student, do not use this form)

All incoming Emory students must meet the CDC and American College Health Association immunization guidelines. Be sure to have THIS FORM SIGNED BY YOUR HEALTHCARE PROVIDER. For immunizations that cannot be verified by your healthcare provider, you may attach a copy of your official, signed immunization record. If for any reason you or your healthcare provider feel that you cannot comply with any of Emory’s immunization requirements (including medical contraindications to specific vaccinations), please attach a letter of explanation signed by both you and your healthcare provider. If possible, please complete all vaccinations PRIOR TO MATRICULATION; however, if a multi-dose vaccination series has been started prior to arrival at Emory, but not yet completed, it can be completed at Emory Student Health. For more information about required immunizations, including indications and contraindications, please visit www.studenthealth.emory.edu/hs/new.students/immunization/index.html.

Required immunizations

1. Measles, Mumps and Rubella Requirement: All students born on or after January 1, 1957 must meet this requirement, either by having been vaccinated against the three diseases (either as the combined vaccine MMR or individual vaccinations against the 3 diseases) or showing laboratory evidence of immunity to all 3 diseases.

   EITHER

   Measles, Mumps, Rubella (MMR)
   □ Dose 1: At 12 month of age or older (provide month, day, year) and Date: __/__/____
   □ Dose 2: At least one month after dose 1 (provide month, day, year) Date: __/__/____

   OR ALL THREE OF THE FOLLOWING

   Measles (Rubella, Red Measles or Ten-Day Measles) – Two doses of vaccine or a positive antibody titer
   □ Dose 1: At 12 months of age or older (provide month, day, year) and Date: __/__/____
   □ Dose 2: At least one month after dose 1 (provide month, day, year), or Date: __/__/____
   □ Positive antibody titer (include copy of lab result) Date: __/__/____

   Mumps – Two doses of vaccine or a positive antibody titer
   □ Dose 1: At 12 months of age or older (provide month, day, year) and Date: __/__/____
   □ Dose 2: At least one month after dose 1 (provide month, day, year), or Date: __/__/____
   □ Positive antibody titer (include copy of lab result) Date: __/__/____

   Rubella (German Measles or Three-Day Measles) – One dose of vaccine or a positive antibody titer
   □ Dose 1: At 12 months of age or older (provide month, day, year) or Date: __/__/____
   □ Positive antibody titer (include copy of lab result) Date: __/__/____

2. Tetanus-Diphtheria Requirement: All students must have the basic primary series of 3 doses of Diphtheria-Tetanus Toxoid (DTP or DTaP).
   □ Tdap Date: __/__/____ or □ Td booster within past 10 years Date: __/__/____

3. Hepatitis B Requirement: All students must have received three doses of vaccine, properly spaced, or show laboratory evidence of immunity.
   □ Date: __/__/____ or
   □ Dose 1 Date: __/__/____ or
   □ Dose 2 Date: __/__/____ or
   □ Dose 3 Date: __/__/____
   □ Positive antibody titer (include copy of lab result) Date: __/__/____

4. Varicella (Chicken Pox) Requirement: History of Varicella (chicken pox) disease, 2 doses of vaccine at 12 months of age or older and at last one month apart, or a positive antibody titer.
   □ Date: (month/year) __/__/____ or
   □ Varicella vaccination
   □ Dose 1 Date: __/__/____ or
   □ Dose 2 Date: __/__/____
   □ Positive varicella antibody titer (include copy of lab result) Date: __/__/____

5. Tuberculosis Screening Requirement: Applies to All Students. Please refer to and complete the Tuberculosis Screening Requirement section on the next page.

Vaccinations recommended but not required:

6. Polio Immunization: It is recommended that all students have a certified primary series of polio immunization (oral or inactivated).
   □ Completed primary series of polio immunization. Type: Oral ___ Inactivated ___ Completion Date: __/__/____

7. Meningococcal (Meningitis ACWY and Men B) Vaccinations: All new college students living in on campus housing in the State of Georgia must complete a form either verifying meningitis vaccinations or specifically declining vaccinations. For more information, visit the EUSHS web site at http://www.studenthealth.emory.edu/hs/new_students/index.html#step%20three. To ensure immunity, CDC recommends a booster dose of ACWY prior to entering college if it has been longer than 5 years since the last meningitis vaccine. MenB vaccines series to provide short-term protection against most strains of serogroup B meningococcal disease.
   □ Meningococcal (ACWY) Vaccine (month, day, year) Date: __/__/____
   □ Meningococcal B vaccine (month, day, year) Date: __/__/____

8. Other Vaccinations, such as Hepatitis A, Pneumococcal, HPV, Typhoid, Yellow Fever, Rabies (include month, day, year):

Verification of the above Student Immunization Record by Healthcare Provider:

Verified by: ___________________________ Address: ___________________________
Name/Title of Healthcare Provider: ___________________________ Phone: ___________________________
Signature of Healthcare Provider: ___________________________ Date: __/__/____
TUBERCULOSIS SCREENING REQUIREMENT

Within six months of matriculation student must complete sections A and B. Healthcare providers please review sections A and B and complete section C if necessary. Forms must be signed and returned.

Name (please print): ____________________________ Emory ID# ____________________________

Country of Birth: ________________________________

Section C: Student Signature ___________________________________________________________

Section A: History of Tuberculosis (TB)?
1. Have you ever been sick with tuberculosis? Yes □ No □
2. Have you ever had a positive Tuberculosis skin test: PPD/TST or positive blood test (IGRA): TB Quantiferon or T-Spot

Section B: At Risk for Tuberculosis (TB)?
1. Are you currently in a health-related academic program/major? Yes □ No □
2. Are you an international student from any countries not on the low incidence list on page 3? Yes □ No □
3. Have you had HIV Infection, AIDS, diabetes, leukemia, lymphoma or a chronic immune disorder? Yes □ No □
4. Are you immunocompromised due to a disease or medication? Yes □ No □
5. Do you have any of the following conditions or situations apply to you
   a) Do you have a persistent cough (3 weeks or more), fever, night sweats, fatigue, loss of appetite or weight loss? Yes □ No □
   b) Have you ever lived with or been in close contact to a person known or suspected of being sick with TB? Yes □ No □
   c) Have you ever lived, worked, or volunteered in any homeless shelter, prison/jail, hospital or drug rehabilitation unit, nursing home or residential health care facility? Yes □ No □

Student Signature ____________________________ Date ____________________________

Section C: TO BE COMPLETED BY HEALTHCARE PROVIDER:
1. If patient answered NO to all questions above no further testing is required.
2. If patient answered YES to any of the above questions a PPD and/or a blood test is REQUIRED. If results are negative no further testing is recommended. *(History of BCG vaccination does not prevent testing. An IGRA blood test is preferred).
3. Chest x-ray is REQUIRED to rule out active disease if PPD results and/or TB blood test are positive.
4. Copies of lab reports and radiology reports are required if performed

PPD: Date placed_____________ Date read_____________ #mm induration_____________

Quantiferon-TB Gold or T-Spot (IGRA) Result Date________________________ Result (attach lab report)________________________

Date of chest x-ray_____________ Result (attach radiologist report)________________________

If diagnosed with latent TB did patient complete a course of medication? Yes □ No □
If yes Med(s): ____________________________ when? _____________ duration? _____________
   (name of medication) ____________________________ (month & year) ____________________________ (# of months)________________________

PROVIDER INFORMATION REQUIRED

Signature of Healthcare Provider ____________________________ Name of Healthcare Provider ____________________________ Phone number ____________________________ Date ____________________________

This paper form serves to provide verification of your immunization information. TWO STEPS ARE REQUIRED FOR IMMUNIZATION COMPLIANCE.

- **Step 1**, please enter the information on this form electronically into Your Patient Portal at [https://www.shspnc.emory.edu/](https://www.shspnc.emory.edu/)
- **Step 2**, please submit a copy of this form. Please be certain that all applicable sections and signatures have been completed (including the signature of your healthcare provider) and that you have met all applicable Emory University immunization requirements.
- To submit the completed and verified immunization document, the preferred method is to upload a PDF version of the form through your Patient Portal at [https://www.shspnc.emory.edu/](https://www.shspnc.emory.edu/).
- If you are unable to upload this form, then choose one of the following: 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 404-727-5349
- Mail to: Emory University Student Health Services, ATTN: Immunization Department, 1525 Clifton Road NE, Atlanta, GA 30322
If your country is not listed here please check “Yes” on Section B question #2

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<th>Countries with low TB incidence include:</th>
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