



Student Name: _____ Emory Student ID#: _____
Date of Birth (mm/dd/yyyy): ___/___/_____ Date form completed: ___/___/_____
School (Emory College, Medicine, Law, etc.): _____

STUDENT IMMUNIZATION RECORD – PAPER VERSION

All incoming Emory students must meet the CDC and American College Health Association immunization guidelines. Please carefully review the Emory immunization requirements and complete the information below. Be sure to have the form verified by the signature of your healthcare provider or enclose a copy of your official, signed immunization records. If for any reason you or your healthcare provider feels that you cannot comply with some or all 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. Please also note that if a multi-dose vaccination series has been started prior to arrival at Emory, but not yet completed, it can be completed at the EUSHS Immunization Clinic. For more information about Emory’s required immunizations, including indications and contraindications, please visit our web site at www.emory.edu/uhs/immunize.html.

All Emory students must have the following required immunizations (or complete them after arrival at Emory):

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 4-6 years of age or older (provide month, day, year) Date: ___/___/_____

OR ALL THREE OF THE FOLLOWING

Measles (Rubeola, 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 4-6 years of age or older (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 4-6 years of age or older (provide month, day, year), or Date: ___/___/_____
Positive Antibody Titer (include copy of lab result) Date: ___/___/_____

Rubella (German Measles or Three-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 4-6 years of age or older (provide month, day, year), or Date: ___/___/_____
Positive Antibody Titer (include copy of lab result) Date: ___/___/_____

2. Tetanus-Diphtheria (Pertussis) Requirement: All students must have the basic primary series of 3 doses of Diphtheria-Tetanus Toxoid (Td or Tdap). These are usually given with Pertussis vaccine (DPT) in infancy. In addition, all students must have a Td or Tdap booster within the past 10 yrs.

- Primary series of 3 doses of Diphtheria and Tetanus immunizations (provide completion date of series), and Date: ___/___/_____
Tdap booster within the past 10 years (REQUIRED for SOM, Allied Health and Nursing) or Td booster within past 10 yrs Date: ___/___/_____

3. Hepatitis B Requirement: All students must have a series of 3 Hepatitis B vaccinations (an initial dose, followed by a dose at 1-2 months and a dose at 4-6 months or later). A post-vaccine quantitative antibody titer is required before arrival for students in healthcare fields (must attach copy).

- Dose 1 Date: ___/___/_____ Dose 2 Date: ___/___/_____ Dose 3 Date: ___/___/_____
Post-vaccine quantitative antibody titer (healthcare students only; attach copy): Titer _____ Date: ___/___/_____

4. Varicella (Chicken Pox) Requirement: All students must have a history of Varicella (chicken pox), a positive Varicella antibody titer or 2 doses of vaccine given at least 1 month apart. Allied Health, Medical and Nursing students must have either 2 vaccines or a Varicella Antibody Titer.

- History of Varicella (chicken pox): Yes _____ No _____
Varicella Antibody Titer (include copy of lab result): Positive _____ Negative _____ Date: ___/___/_____
Varicella Vaccination Dose 1 (provide month, day, year) Date: ___/___/_____
Varicella Vaccination Dose 2 (at least one month after Dose 1, provide month, day, year) Date: ___/___/_____

5. Tuberculosis Screening Requirement: All Allied Health, Medical and Nursing students and International Students from certain countries with endemic Tuberculosis must meet Emory’s Tuberculosis Screening Requirement. This requirement is in keeping with current CDC guidelines. Please refer to and complete the “Tuberculosis Screening Requirement” section on the next page if you are a member of one of these groups.

Vaccinations recommended but not required:

Please note that individual schools may require certain vaccinations on the list below due to increased levels of risk/exposure.

6. Polio Immunization: It is recommended that all students have a certified primary series of polio immunization (oral, inactivated or E-IPV).

- Completed primary series of polio immunization. Type: Oral ___ Inactivated ___ E-IPV ___ Completion Date: ___/___/_____

7. Meningococcal (Meningitis) Vaccination: Effective January 2004, all new college students living in on campus housing in the State of Georgia must complete a form either verifying meningitis vaccination or specifically declining vaccination. For more information, visit the EUSHS web site at www.emory.edu/uhs/. To insure immunity, CDC recommends a booster dose prior to entering college if it has been longer than 5 years since last meningitis vaccine.

- Meningococcal Vaccine (provide month, day, year) Date: ___/___/_____

8. Other Vaccinations, such as Hepatitis A, Pneumococcal, HPV (include month, day, year): _____

Verification of the above Student Immunization Record by healthcare provider:

Verified by: _____ (_____) _____
Name/Title of Healthcare Provider Address Phone

Signature: _____ Date: ___/___/_____

Student Name: _____

Emory Student ID#: _____

Date of Birth (mm/dd/yyyy): ___/___/_____

TUBERCULOSIS SCREENING REQUIREMENT

Emory University requires Tuberculosis (TB) screening (PPD skin testing and/or chest x-ray) within 6 months of matriculation of all Allied Health, Medical and Nursing Students and all International Students who have arrived in the United States within the past 5 years from countries in which Tuberculosis is endemic. Allied Health, Medical and Nursing Students will also need a second PPD (the "two step" PPD process) at least 2 weeks after the first. Emory's guidelines are based upon the recommendations of the CDC, the American Thoracic Society and the American College Health Association.

If you come from a TB endemic country, your TB screening must be performed using a Quantiferon Gold or T-spot blood test. Because TB is so common globally, it is easier to list countries of low TB prevalence rather than high. Countries with low TB prevalence include Canada, Jamaica, St. Kitts and Nevis, St. Lucia, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Iceland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marcos, Sweden, Switzerland, United Kingdom, United States, American Samoa, Australia or New Zealand. **If you are from a country not on this list, you will need one of the blood tests instead of the PPD.**

Please complete the information below if you are a member of one the following groups: **Allied Health Student** _____ **Medical Student** _____
Nursing Student _____ **International Student from a country not on the list above** _____ (Name of Country _____)

1. **Tuberculin Skin Test (PPD/Mantoux only) (Tine NOT acceptable):** Date Placed: ___/___/___ Date Read: ___/___/___
Result: _____mm (Record actual mm of induration, transverse diameter. If no induration, record as "0 mm.")
Interpretation (based on mm of induration as well as risk factors): Positive _____ Negative _____

PPD#2 (for Nursing students, complete before arrival; For Medical and Allied Health students, will be done here during your first month at Emory): Date Placed: ___/___/___ Date Read: ___/___/___
Result: _____mm (Record actual mm of induration, transverse diameter. If no induration, record as "0 mm.")
Interpretation (based on mm of induration as well as risk factors): Positive _____ Negative _____

2. **Chest X-ray** (Required if PPD skin test is positive. Please attach a copy of the CXR report): Normal _____ Abnormal _____ Date Read: ___/___/___

3. **Blood tests: QuantiFERON Gold TB or T-Spot (circle test used):** Positive _____ Negative _____ (must attach a copy of the result)

4. **Treatment:** Have you been treated with anti-tubercular drugs? Yes _____ No _____
If yes, type of treatment: _____ Length of treatment: _____

Verification of the above Tuberculosis Screening by healthcare provider:

Verified by: _____ (_____) _____
Name/Title of Healthcare Provider Address Phone

Signature: _____ Date: _____

This is a paper version of a form that is now completed electronically via *Your Patient Portal* at https://www.shspnc.emory.edu/login_directory.aspx. If you need to use this paper version of the form, please be certain that all questions are answered, all signatures are completed (including the signature of your healthcare provider) and that you have met all applicable Emory University Immunization Requirements.

You may scan/email, mail or fax your signed/verified immunization record to:

**Emory University Student Health Services
ATTN: Immunization Nurse
1525 Clifton Road NE, Atlanta, GA 30322
FAX # 404-727-5349**

If you wish to scan and email your immunization records to us, it is very important that you **send this email from your emory.edu email address** (e.g. lord.dooley@emory.edu). If you use a non-Emory email address (e.g. gmail, yahoo, etc.), your email and immunization documents will be outside the Emory firewall and we cannot guarantee their security. We prefer scanned **.pdf** documents, because these can be uploaded directly into your Student Health Services personal electronic medical record. Other document formats must be re-printed/re-scanned and can be very difficult to read, including .jpeg documents. Thank you!

Send your scanned immunization documents to: **Immunizations-SHS@emory.edu**

This space below is reserved for use by Emory University Student Health Services personnel only

Reviewed by _____ Date Reviewed _____ Date Completed _____
Comments _____ Date(s) deficiency notice(s) sent _____