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 EUSHCS 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 months of age or older (provide month, day, year) and
     - Dose 2: At 4-6 years of age or older (provide month, day, year) 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
     - Dose 2: At 4-6 years of age or older (provide month, day, year), or
     - Positive Antibody Titer (include copy of lab result)
   - Mumps – Two doses of vaccine or a positive antibody titer
     - Dose 1: At 12 months of age or older (provide month, day, year) and
     - Dose 2: At 4-6 years of age or older (provide month, day, year), or
     - Positive Antibody Titer (include copy of lab result)
   - 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
     - Dose 2: At 4-6 years of age or older (provide month, day, year), or
     - Positive Antibody Titer (include copy of lab result)

2. Tetanus-Diphtheria 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
   - Td booster within the past 10 years or Tdap booster within past 10 years

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 antibody titer (to demonstrate immunity) is required for students in healthcare fields.
   - Dose 1 Date: ______/_____/______
   - Dose 2 Date: ______/_____/______
   - Dose 3 Date: ______/_____/______
   - Post-vaccine antibody titer (required for students in healthcare fields): Positive ______ Negative ______ 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
   - History of Varicella (chicken pox): Yes ______ No ______
   - Varicella Antibody (include copy of lab result): Positive ______ Negative ______ Date: ______/_____/______
   - Varicella Vaccination Dose 1 (provide month, day, year)
   - Varicella Vaccination Dose 2 (at least one month after Dose 1, provide month, day, year)

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:

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 EUSHCS web site at www.emory.edu/uhs/.
   - Meningococcal Vaccine (provide month, day, year)

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: _______________________________ Date: ______/_____/______

Name/Title of Healthcare Provider ___________________________ Phone ___________________________

Signature: __________________________________________________________________________ Date: ______/_____/______

Emory University Student Health and Counseling Services
1525 Clifton Road, Atlanta, Georgia 30322 404.727.7551

Form revised July 2018 (2)
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.

Because TB is so common globally, it is easier to list countries of low TB prevalence rather than high. Therefore, all International Students who have arrived in the United States within the past 5 years are required to undergo Tuberculosis (TB) screening EXCEPT those from the following countries:

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, American Samoa, Australia or New Zealand

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 ______

2. **PPD#2 (for Allied Health, Medical and Nursing Students, may be done either before or after arrival 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 ______

3. **Chest X-ray (Required if PPD skin test is positive):** Date Read: __/__/____
   - Normal  ___ Abnormal  ____

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. Mail this form to:

Director of Nursing Services
Emory University Student Health and Counseling Services
1525 Clifton Road
Atlanta, GA 30322

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

Reviewed by ___________________________ Date Reviewed ________________ Date Completed ________________
Comments ___________________________ Date(s) deficiency notice(s) sent __________________

Form revised July 2010 (2)