



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

STUDENT IMMUNIZATION RECORD

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.studenthealth.emory.edu/.

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) – both 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 – a single dose of vaccine or a positive antibody titer

- Vaccine at 12 months 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) – a single dose of vaccine or a positive antibody titer

- Vaccine 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 (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:** ____/____/____
 Td booster within the past 10 years **or** Tdap booster within past 10 years **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 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 ____ **Date:** ____/____/____
 Varicella Antibody (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 EUSHCS web site at www.studenthealth.emory.edu/.*

- 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. 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 _____

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 _____

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

3. 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: _____

HEALTH INSURANCE INFORMATION: All degree-seeking and international Emory students are required to either provide proof of insurance coverage via OPUS at the start of each Fall Semester or enroll in the Emory University Student Health Insurance Plan. If you wish to also provide us with your insurance information, which may speed your check-in and check-out process at EUSHCS visits, you may do so below.

Insurance Company _____ Policy Number _____
Address _____ Name of Policy Holder _____
SS# of Policy Holder _____

Please check this box if you are not currently insured but you intend to buy the Emory-endorsed student health insurance plan.

CONSENT FOR TREATMENT AND STATEMENT OF ACCURACY

I hereby consent to receive medical care (or for my minor child or ward under 18 years of age to receive medical care) from Emory University Student Health and Counseling Services, or from the professional staff of any other Emory Healthcare facility, including but not limited to The Emory Clinic, Emory University Hospital and Crawford Long Hospital of Emory University. I also authorize such treatment, x-rays or other diagnostic studies as, in the judgment of the attending physician, may reasonably be necessary to preserve and protect my health (or the health of my minor child or ward).

By my signature below, I also attest that all statements in this Student Entrance Medical and Immunization Record are true to the best of my knowledge and that I (or my minor child or ward) have (has) no health problems or medical restrictions not listed in this record.

Signature of Student _____ Date _____

If the student is under 18 years of age, this form must be signed by the parent or guardian:

Signature of Parent or Guardian _____ Date _____

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 _____