EMORY UNIVERSITY

Student Health Services
Campus Life
Immunization Form

1525 Clifton Rd NE
Atlanta, GA 30322
Phone# 404-727-7551
Fax # 404-727-7343

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

REQUIRED VACCINATIONS

Vaccine Record: Complete Dates MM/DD/YYYY of vaccine doses given

COVID - 19				
Pfizer	1	2		
Moderna	1	2		
J&J				
MMR (Measles, Mumps Rubella) 2 doses of MMR or lab reports with titers to prove immunity for each				
MMR	1	2	1st dose after 12 months	☐ Attach Lab report
Measles (Rubeola)	1	2	1st dose after 12 months	☐ Attach lab report
Rubella	1		1st dose after 12 months	☐ Attach lab report
Mumps	1	2	1st dose after 12 months	☐ Attach lab report
Hepatitis B either 3 dose series or 2 dose series followed by a positive **QUANTITATIVE** Hepatitis B Surface Antibody (titer) lab report				
Engerix-B	1	2	3	☐ Attach lab report
Heplisav-B	1	2		☐ Attach lab report
Secondary Hepatitis B series				
	1	2	3	☐ Attach lab report
Varicella	1 History of disease not accepted	2	1st dose after 12 months	☐ Attach lab report
Tetanus-Diphtheria Pertussis (Whooping Cough) within the last ten years				
TDAP		TD		
Seasonal Influenza (required for spring semester)				
	1			
Meningococcal Vaccine ACWY 1 (if living on campus)				
	1	2		

Vaccinations Recommended but not Required

Polio	Completed primary series oral___ Inactivated____ Date of completion ____/____/_____		
HPV	1	2	3
Hepatitis A	1	2	
Meningococcal B		1	2
Other Vaccines not listed (BCG , Yellow Fever, Typhoid, Pneumococcal, Japanese Encephalitis, Rabies etc.)			
1 Menningococcal ACWY vaccine must be after 16 years of age			
All Labs must have a lab report attached to form			

Immunization Form Emory School of Medicine, Allied Health Students and School of Nursing

Last Name:	First Name:	Student ID #

Required Tuberculosis Screening For ALL Allied Health School Students

SON: both PPDs or IGRA must be completed within 6 months prior to matriculation.

SOM and all other Allied Health Schools: the first PPD or IGRA (TB blood test) must be adminstered within 6 months prior to matriculation. The second PPD will be administered after matriculation.

Must complete Sections A, B or C

Section A

History of BCG vaccination? **IGRA** required. Or are you from any country listed on page 3? - **IGRA** required	**Date of IGRA**	☐ Attach copy
	____/____/______	

Section B

History of Negative PPDs?		**Date Placed**	**Date Read**	**Reading**
PPD Must be with in 6 months	**PPD #1**	____/____/_____	____/____/______	________mm
	PPD #2	____/____/_____	____/____/______	________mm
TB Blood Test	☐ T-Spot ☐ QuantiFERON Gold		**Date** ____/____/____	☐ Attach copy

Section C

Positive Skin Test? Or Positive IGRA? Or History of Latent TB?

	Date Placed	**Date Read**	**Reading**	
Positive PPD	____/____/_____	____/_____/_____	_____ mm	
Positive IGRA blood Test	**Date** ____/____/____	☐ T-Spot ☐ QuantiFERON Gold	☐ Attach lab report	
Prophylactic medications taken for latent TB	☐ yes ☐ no		☐ attach documentation	
Chest x-ray only if TB testing positive	Chest X-Ray ☐		Date____/____/____	☐ attach report

For verification of your immunization information, two steps are required:

Step 1: Please enter the information on this form electronically into your patient Portal found here: https://www.shspnc.emory.edu

Step 2 : Please submit a copy of this form. Ensure that the form is signed and all sections completed and that you have met all applicable Emory University immunization requirements.

Submitting the form: TWO STEPS REQUIRED

1. Please enter the information on this form electronically into your Patient Portal: at www.shspnc.emory.e

2. Upload a PDF version of the form through your Patient Portal (Preferred Method**)**

OR: Scan and email to immunizations-shs@emory.edu. We advise you to use your Emory email address (e.g. lord.dooley@emory.edu) OR Fax: 404-727-7343 OR Mail to Emory University Student Health Services ATTN Immunization Department, 1525 Clifton RD NE, Atlanta, GA 30322

First and Last Name must be on each page

Signature of Student ______________________________________ **Date**____________________

FORM MUST BE COMPLETED AND SIGNED BY YOUR HEALTHCARE PROVIDER

Authorized Signature		Date ____/____/____
Printed Name and Title		
Address Line 1		
City/State/ Zip/Phone		

Immunization Form Emory School of Medicine, Allied Health Students and School of Nursin g

Are you from any of these countries? If so, please complete Section A on page 2

Countries and Territories with High Incidence of Active Tuberculosis Disease				
Afghanistan	Comoros	Iraq	Namibia	Somalia
Algeria	Congo	Kazakhstan	Nauru	South Africa
Angola	Cote d'Ivoire	Kenya	Nepal	South Sudan
Anguilla	Democratic People's Republic	Kiribati	New Caledonia	Sri Lanka
Argentina	of Korea	Kuwait	Nicaragua	Sudan
Armenia	Democratic People's Republic	Kyrgyzstan	Niger	Suriname
Azerbaijan	of the Congo	Lao People's Democratic	Nigeria	Swaziland
Bangladesh	Djibouti	Republic	Northern Mariana	Syrian Arab Republic
Belarus	Dominican Republic	Latvia	Islands	Tajikistan
Belize	Ecuador	Lesotho	Pakistan	Tanzania(United
Benin	El Salvador	Liberia	Palau	Republic of)
Bhutan	Equatorial Guinea	Libya	Panama	Thailand
Bolivia (Pluirnational State of	Eritrea	Lithuania	Papua New Guinea	Timor-Leste
Bosnia and Herzegovina	Ethiopia	Madagascar	Paraguay	Togo
Botswana	Fiji	Malawi	Peru	Tunisia
Brazil	Gabon	Malaysia	Philippines	Turkmenistan
Brunei Darussalam	Gambia	Maldives	Portugal	Tuvalu
Bulgaria	Georgia	Mali	Qatar	Uganda
Burkina Faso	Ghana	Marshall Islands	Republic of Korea	Ukraine
Burundi	Greenland	Mauritania	Republic of Moldova	Uruguay
Cabo Verde	Guam	Mauritius	Romania	Uzbekistan
Cambodia	Guatemala	Mexico	Russian Federation	Vanuatu
Cameroon	Guinea	Micronesia)Federated	Rwanda	Venezuela
Central African Republic	Guinea -Bissau	States of)	Sao Tome and Principe	(Bolivarian
Chad	Guyana	Mongolia	Senegal	Republic of)
China	Haiti	Montenegro	Serbia	Viet Nam
China, Hong Kong SAR	Honduras	Morocco	Sierra Leone	Yemen
China, Macao SAR	India	Mozambique	Singapore	Zambia
Columbia	Indonesia	Myanmar	Solomon Islands	Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. Countries with incidence rate of > 20 cases per 100,000 population.

Student Signature____ Date______________

For verification of your immunization information and to upload this form, TWO STEPS are required:
STEP 1: Please enter the information on this form electronically into your Patient Portal at www.shspnc.emory.edu
Step 2: Please Upload a PDF version of this form through your Patient Portal (PREFERRED METHOD)
If unable to upload, email the form to Immunizations-shs@emory.edu (using your Emory student email address)