Academic Year:_____

EMORY UNIVERSITY | Student Health Services
Campus Life

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

Immunization Form

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 (*Check One*) ☐ AA ☐ DPT ☐ Genetic Couns ☐ Med Imaging ☐ MD ☐ Nursing ☐ PA

REQUIRED VACCINATIONS

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

COVID-19 *(may be program required)*		*must be WHO approved		**Booster**	**Most Recent Dose**
Pfizer	1	2			
Moderna	1	2			
J&J					
Other/Brand*					

MMR (Measles, Mumps, Rubella): *2 doses of MMR OR provide lab tests indicating immunity to Measles, Mumps and/or Rubella*				
1st dose after 12 months of age				
MMR	1	2	☐ Attach **required** lab report	
Measles (Rubeola)	1	2	☐ Attach **required** lab report	
Mumps	1	2	☐ Attach **required** lab report	
Rubella	1		☐ Attach **required** lab report	

Hepatitis B: *either 3 dose series or 2 dose series **AND** a positive **QUANTITATIVE** Hepatitis B Surface Antibody (titer) lab report*					
Engerix-B	1	2	3		☐ Attach **required** lab report
Heplisav-B *(vaccine available beginning Nov 2017)*	1	2			☐ Attach **required** lab report
Secondary Hepatitis B series	1	2	3		
	1	2	3		☐ Attach **required** lab report

Varicella: *2 doses of Varicella OR a Varicella IgG positive titer indicating immunity*		
*History of disease **not** accepted (1st dose after 12 months of age)*		
1	2	☐ Attach **required** lab report

Tetanus-Diphtheria Pertussis (Tdap): *one Tdap required at or after age 11 and a booster every ten years*			
Tdap		Recent Tdap	

Seasonal Influenza (required for spring semester)	
1	

Meningococcal Vaccine ACWY: *one dose after 16 years of age (if living on campus)*	
1	2

Vaccinations Recommended but not Required

Meningococcal B	1	2	3 (if applicable)
Polio	Completed primary series Oral ___ Inactivated ___ Date of completion ____/____/_____		
HPV	1	2	3
Hepatitis A	1	2	

Other Vaccines not listed (BCG, Yellow Fever, Typhoid, Pneumococcal, Japanese Encephalitis, Rabies, etc.):					
Vaccine		Vaccine		Vaccine	
Date		Date		Date	

If compliance is achieved with titers, must attach lab reports to this 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 Health Science Students

IGRA must be completed within 6 months prior to matriculation.

Must complete Sections A, B, or C

Section A		
History of BCG vaccination? Check one: ☐ NO or ☐ YES If yes, IGRA required		
Or are you from any country listed on page 3? Check one: ☐ NO or ☐ YES	**Date of IGRA**	
If yes, list the Country: *IGRA required*	____/____/_____	☐ Attach **required** lab report

Section B		
If submitting IGRA, must be within 6 months prior to matriculation:	**Date of IGRA**	
☐ TB Blood Test ☐ T-Spot ☐ QuantiFERON Gold	____/____/____	☐ Attach **required** lab report

Section C				
If submitting PPDs, must be within 6 months		**Date Placed**	**Date Read**	**Reading**
	PPD #1	____/____/_____	____/____/_____	_____mm
	PPD #2	____/____/_____	____/____/_____	_____mm

Section D				
Positive IGRA? Or Positive Skin Test? Or History of Latent TB?				
Positive IGRA blood Test	**Date** ____/____/____	☐ T-Spot ☐ QuantiFERON Gold	☐ Attach lab report	
Positive PPD	**Date Placed** ____/____/____	**Date Read** ____/_____/_____	**Reading** _____mm	
TB Prophylaxis: If diagnosed with latent TB, did the patient complete a course of medication?			☐ Yes ☐ No	☐ Attach documentation
If yes, medication(s):_____ When? _____ Number of months: _____				
Chest x-ray only if TB testing positive		☐ Chest X-Ray	Date___/____/____	☐ Attach Chest X-Ray repor

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

Step 1: Enter the information on this form electronically into the Student Patient Portal (www.shspnc.emory.edu)

Step 2: Upload a completed PDF of this form to the Patient Portal. Ensure that the form is signed, all sections are completed, and that you have met all applicable Emory University immunization requirements. ***(**Preferred Method**)***

OR: Scan and email completed form to immunizations-shs@emory.edu. (We advise using your @emory.edu email address.)

OR: Fax completed form to 404-727-7343

OR: Mail to Emory University Student Health Services, ATTN: Immunization Dept., 1525 Clifton Rd NE, Atlanta, GA 30322

First and Last Name must be on each page

Signature of Student _____ **Date** ___/____/____

FORM MUST BE COMPLETED, SIGNED AND STAMPED BY YOUR HEALTHCARE PROVIDER

Authorized Signature _____ Date ___/____/____

Printed Name and Title _____

Address Line _____

City/State/ Zip/Phone _____

Clinic/Provider Stamp:

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

Last Name: _____ First Name: _____ Student ID # _____

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

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

Signature of Student _____ **Date** ___/____/____