Augusta University
Student Health Services
706-721-3448
immunizations@augusta.edu

Name: ______________________________________
Date of Birth: ___/_____/__________
Student ID: ____________________________

AUGUSTA UNIVERSITY CERTIFICATE OF IMMUNIZATION

Your health care provider must complete and sign this form. All information must be written in English.

This document must be submitted at least two (2) weeks prior to registration.

Please follow the directions at http://www.augusta.edu/shs/immunizations.php to submit your record.

REQUIRED IMMUNIZATIONS & TESTS

Vaccine	Date: M/DD/YYYY	REQUIRED FOR & WHAT is needed
MMR (measles, mumps, rubella)	#1: ___/___/___ #2: ___/___/___	**REQUIRED for students born after Jan. 1, 1957: vaccine or antibody titer**. **WHAT:** Two (2) doses of combined measles-mumps- rubella or "MMR" or separate vaccines for each measles, mumps, and rubella. The first dose of all vaccine types must be given at 12 months of age or later and the second dose of the MMR, measles, mumps at least 28 days after the first dose ***OR*** - Attach copy of lab report of IgG blood antibody titer results for each virus: measles, mumps, rubella as evidence of immunity.
Varicella	#1: __/__/___ #2: __/__/___ ***OR*** Chicken Pox disease: __/__/___	**REQUIRED** for all students. **WHAT:** 2 doses given at least 3 months apart if both doses are given before age 13 ***OR*** - 2 doses at least 4 weeks apart if first dose is given after 13th birthday ***OR*** - documented history by physician of chicken pox or shingles ***OR*** - Attach copy of lab report of IgG antibody titer results as evidence of immunity.
Tetanus, Diphtheria, Pertussis (TDaP)	_____/____/____ If TDaP is > 10 years old, date of last Tetanus booster: ____/____/____	**REQUIRED** for all students. **WHAT:** One Tdap dose administered after 6/10/2005. If TDaP is was administered more than 10 years ago, then a Td booster dose is ALSO required.
Hepatitis B	#1: ____/____/____ #2: ____/____/____ #3: ____/____/____	**REQUIRED** for all students who will be 18 years of age or less at the time of expected enrollment date. **WHAT:** 3 dose of hepatitis B series (given at 0, 1-2, and 4-6 months) ***OR*** -3 dose combined hepatitis A and hepatitis B series (at 0, 1-2 and 6-12 months) ***OR*** -2 dose hepatitis B series of Recombivax (at 0 and 4-6 months) given at 11-15 years of age **OR** -Attach copy of lab report of Hep B surface antibody titer results.
Tuberculosis (TB)	TB Screening Questionnaire on Page 2	**REQUIRED**: All students must complete the "TB screening questionnaire" on page 2.
Meningococcal (ACWY (MCV4)	#1 ___/___/___ **&** #2: ___/___/___ if initial dose more than 5 years ago	**REQUIRED:** All students living in on-campus housing or sorority/fraternity housing. **WHAT**: One dose if unvaccinated. If the initial dose given more than 5 years ago, a booster is required. A student may sign a waiver and statement of understanding by going to: https://www.augusta.edu/shs/immunizationwaivers.php

STRONGLY RECOMMENDED IMMUNIZATIONS (NOT REQUIRED):

Vaccine	Date: MM/DD/YY	Date: MM/DD/YY	Date: MM/DD/YY	Notes:
COVID-19	/ /	/ /	/ /	Type:
Hepatitis A	/ /	/ /	Strongly recommended if travel outside of U.S.	
Meningococcal B	/ /	/ /	/ /	(Bexsero or Trumenba – circle type given)
HPV	/ /	/ /	/ /	males and females through age 45 years
Influenza	/ /	-------		

I attest that all of the above information is accurate and agree to release this information to Augusta University Student Health.

Student Signature: ____**Date:** ______________

REQUIRED SIGNATURE OF licensed HEALTHCARE CLINICIAN*

Name: ____

Address: ____________________________________ Phone: _____________

Signature: ____ Date: ________________________

* Healthcare Clinician can be a U.S. licensed physician, nurse practitioner, physician assistant or registered nurse.

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https://www.augusta.edu/shs/documents/undergradform.pdf

Please answer these questions –by checking the appropriate box ("Yes" or "No"):

1. Have you had close contact with persons known or suspected to have active TB? □ Yes □ No
2. Were you born in one of the countries listed below that have a high incidence of active TB? □ Yes □ No
   If yes, please **circle** the country below.

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Republic
Chad
China
Colombia
Comoros
Congo

Côte d'Ivoire
Croatia
Democratic People's Republic
Korea
Democratic Republic of the
Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq

Japan
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic
Republic
Latvia
Lesotho
Liberia
Libyan Arab Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Micronesia (Federated States
of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nepal

Nicaragua
Niger
Nigeria
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the
Grenadines
Sao Tome and
Senegal
Seychelles
Sierra Leone
Singapore
Solomon
Somalia
South Africa
Sri Lanka

Sudan
Suriname
Tajikistan
Thailand
Timor-Leste
Togo
Yokelau
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Un. Rep. of Tazania
Uruguay
Uzbekistan
Venezuela (Bol. Rep.)
Vietnam
Yemen
Zambia
Zimbabwe

3. Have you had frequent or prolonged visits to one or more of the countries listed above? □ Yes □ No
   If yes, **check** the applicable countries.
4. Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, homeless shelters, long-term care facilities, etc.) □ Yes □ No
5. Have you been a volunteer or healthcare worker who served clients/patients who were at increased risk for active TB disease? □ Yes □ No
6. Have you ever been a member of any of the following groups that may have an increased incidence of latent or active TB disease: medical underserved, low-income, or abusing drugs or alcohol? □ Yes □ No
7. Have you ever had a positive TB skin test or IGRA blood test? □ Yes □ No
8. Have you had the BCG* vaccination? □ Yes □ No
   **The BCG vaccination is a vaccine for TB that is typically given in foreign countries with a higher incidence of TB. For more information regarding this vaccine, visit: https://www.cdc.gov/vaccines/vpd/tb/index.html .*

ATTESTATION STATEMENT:

I attest that the above information is accurate.

Student Signature: ____Date: ______________

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CLINICAL ASSESSMENT BY HEALTHCARE CLINICIANS

1. Please review and verify the TB Questionnaire responses. If any are answered "YES", they are candidates for either tuberculin skin test or Interferon Gamma Release Assay (IGRA) unless a previous positive test has been documented.
2. History of positive TB skin test or IGRA blood test? ☐ Yes (document below) ☐ No
   History of BCG vaccination? ☐ Yes (consider IGRA if possible) ☐ No
3. TB Symptoms Check: Does the student have signs or symptoms of active pulmonary TB disease? ☐ Yes ☐ No
4. Proceed with further tests to exclude active TB, including chest X-ray as medically indicated.
5. Diagnostic/screening tests:
   - Tuberculin Skin Test (TST):
     - Date Given: ______________________ Date Read: ______________________
     - Skin test result = ____________mm induration; interpretation* = ☐ positive ☐ negative
   - Interferon Gamma Release Assay (IGRA) (Required if TST is positive. Lab report must be attached)
     - Date obtained: ____/____/____ Specify method: ☐ QFT-GIT ☐ T-spot ☐ other
     - Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ borderline (T-spot only)
   - Chest X-ray (required if IGRA is positive):
     - Date of chest X-ray: _____/_____/____ Result: ☐ normal ☐ abnormal (acute pulmonary TB)

<u>*TST Interpretation guidelines</u>:

≥ 5 mm is positive:
- recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunocompromised persons

≥ 10mm is positive:
- recent arrival to the U.S. (<5 years) from high prevalence areas
- injection drug users
- Mycobacteriology lab personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease, including immunosuppressive disorders, silicosis, diabetes mellitus, chronic renal failure, and certain types of cancer (e.g., leukemias and lymphomas, cancers of head/neck/lung), gastrectomy or jejunoileal bypass, weight loss > 10% below ideal body weight.

≥ 15 mm is positive:
- persons with no known risk factors for TB

REQUIRED SIGNATURE OF HEALTHCARE CLINICIAN*
Name: ___________________________ Address: ____ Phone: _______________
Signature: ____ Date: ____________________________

* Healthcare Clinician can be a U.S. licensed physician, nurse practitioner, physician assistant or registered nurse.