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 the start of semester.

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

REQUIRED IMMUNIZATIONS - Non-Clinical

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*** History of chicken pox: ____/____/____	**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 was administered more than 10 years ago, then a Td/TDaP dose is ALSO required.
Hepatitis B	#1: ____/____/____ #2: ____/____/____ #3: ____/____/____	**REQUIRED for all students.** **WHAT:** 3 dose 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".
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 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:

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	/ /	-------	Annual - September to March; required for health professional students	

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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Submit this page only if you are claiming exemption from the USG Immunization requirements

STUDENT EXEMPTIONS

Select the appropriate box, sign and date if you are claiming exemption of the immunization requirement for one of the following reasons:

☐ I affirm that the immunizations required by the University System of Georgia are in conflict with my religious beliefs. I understand I am subject to exclusion from all on-campus classes and activities in the event of an outbreak of disease for which immunization is required.

☐ I declare that I am enrolling ONLY in online classes and will not be attending any activities on any AU campus. If I subsequently register for even one in-person class, I must provide proof of immunizations at least two (2) weeks before semester.

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

Student Signature: _____**Date:** _____

PERMANENT OR TEMPORARY MEDICAL EXEMPTIONS

Requires signature of licensed healthcare clinician:

☐ I affirm that this student is exempt from the above immunizations due to a permanent medical contraindication.

☐ I affirm that this student is temporarily exempt from the above immunizations until _____/____/_____.

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.

Any questions? Send email to: immunizations@augusta.edu

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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)
     - Date obtained: ____/____/____ Specify method: ☐ QFT-GIT ☐ T-spot ☐ other
     - Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Borderline (T-spot only)
   - Chest X-ray (required if TST or IGRA is positive):
     - Date of chest X-ray: _____/_____/____ Result: ☐ normal ☐ abnormal (acute pulmonary TB)

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*TST Interpretation guidelines:

≥ 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.

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AUGUSTA UNIVERSITY TB SCREENING QUESTIONNAIRE

Please answer the following questions:

1. Have you ever had close contact with persons known or suspected to have active TB disease? ❑ Yes ❑ No
2. Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below.) ❑ Yes ❑ No

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence. Countries with average incidence rates of ≥ 20 cases per 100,000 population.

Tuberculosis Screening and Targeted Testing of College and University Students

3. Have you resided in or traveled to one or more of the countries or territories listed above for a period of one to three months or more? (If yes, CHECK the countries or territories, above) ❑ Yes ❑ No
4. Have you been a resident, volunteer, and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ❑ Yes ❑ No
5. Have you been a volunteer or health care worker who served clients who are 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 M. tuberculosis infection or active TB disease: medically underserved, low-income, or using 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 .*

If you answered YES to any of the above questions, Augusta University requires you to receive TB testing before the start of the semester). The significance of any travel exposure should be reviewed with a health care provider. If the answer to all the above questions is NO, no further testing or further action is required.

ATTESTATION STATEMENT:

I attest that the above information is accurate.

Student Signature: _____ Date: _____