CLARK ATLANTA UNIVERSITY

Student Health Services
Immunization/ Tuberculosis Screening Record

PART I

Name _____ _____
Last, First, M.I Telephone Number

Address _____
Street City State Zip

Date of Enrollment ____/____/____ Date of Birth ____/____/____ School ID# _____
M D Y M D Y

Status: Part-time _____ Full-time _____ Graduate _____ Undergraduate _____

PART II: TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

All information must be in English.

A. MMR (MEASLES, MUMPS, RUBELLA) (Required)

(Two doses required at least 28 days apart for students born after 1956.)

1. Dose 1 given at age 12 months or later ..... #1____/____/____
   M D Y
2. Dose 2 given at least 28 days after first dose ..... #2____/____/____
   M D Y

OR positive antibody titer (blood test) lab report required

B. MENINGOCOCCAL QUADRIVALENT(Required) Polysaccharide acceptable

(A, C, Y, W-135) 2 doses; 2nd dose to be given after age 16

1. Quadrivalent conjugate

a. Dose #1____/____/____ b. Dose #2____/____/____
M D Y M D Y

2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available).

Date ____/____/____
M D Y

C. TETANUS, DIPHTHERIA, PERTUSSIS (Required) (Must be within the last ten years and remain current throughout matriculation)

Date of most recent booster dose: ____/____/____ Type of booster: Td _____ Tdap_____
M D Y *Tdap booster recommended for ages 11-64 unless contraindicated*

D. HEPATITIS B (Required)

Heplisav-B (2 dose series) is not interchangeable with other hepatitis B vaccines (3 dose series) but can substituted for dose #2 and #3.

1. Immunization (hepatitis B)

a. Dose #1 ___/___/_____ b. Dose #2 ___/___/_____ c. Dose #3 ___/___/_____

M D Y — Adult formulation __ Child formulation ____ HepB-CpG (Heplisav-B) ____

M D Y — Adult formulation ____ Child formulation ____ HepB-CpG (Heplisav-B) ____

M D Y — Adult formulation ____ Child formulation ____ HepB-CpG (Heplisav-B) ____

2. Immunization (Combined hepatitis A and B vaccine)

a. Dose #1 ___/___/_____ b. Dose #2 ___/___/_____ c. Dose #3 ___/___/_____

M D Y M D Y M D Y

3. Quantitative hepatitis B surface antibody test (only recommended for individuals born in or whose mother was born in a hepatitis B endemic country, and/or men who have sex with men; required for health science students).

Date ___/___/___ Result: Reactive _____Non-reactive_____
M D Y

E. VARICELLA (Required) *(Positive Varicella Titer is also acceptable for compliance. History of disease is not acceptable).*

1. Immunization

a. Dose #1 ..... #1___/___/___
M D Y

b. Dose #2 ..... #2___/___/___
M D Y

G. Additionally, the following vaccines are strongly recommended for all students.

a. Hepatitis A:___/___/___:___/___/___
M D Y M D Y

b. Meningitis B:___/___/___:___/___/___
M D Y M D Y

c. Influenza: ___/___/___
M D Y

Name:_____ School ID# _____

H. TUBERCULOSIS (TB) RISK ASSESSMENT (to be completed by **health care provider)**

Tuberculin Skin Test (TST) (Required within past 12 months)

(The TST interpretation should be based on mm of induration as well as risk factors.)

Date Given:____/____/____Time:
Date Read:____/____/____ Time:
M D Y

Result:_____mm of induration (Must be numerical) If no duration, write "0".
An induration 10mm or above requires a chest x-ray

****Interpretation: Negative____ Positive _____**

Interferon Gamma Release Assay (IGRA): (**specify method and attach report**) QFT-GIT _____ T-Spot _____ other_____

Result: negative____ positive____ indeterminate____ borderline___(T-Spot only)

Chest x-ray (Attach Report): (Required if TST induration is 10mm or above or IGRA is positive)

Date of chest x-ray:____/____/____ Result: normal____abnormal_____
M D Y

I. Medical Exemption:(Attach Verification by Healthcare Provider)

❑ Exemption on grounds of permanent medical contraindication

❑ Exemption on grounds of temporary medical contraindication- Expected end date____/____/_____
M D Y

J. Religious Exemption:

❑ I affirm that immunizations as required by Clark Atlanta University are on conflict with my religious beliefs. I understand that I am subject to exclusion in the event of a disease for which immunization is required.
(**Attach Notarized Affidavit)**

Notice: Permission is hereby granted for Clark Atlanta University Health Services staff and/or their consultants to carry out indication medical and surgical treatment. Major surgery or illness cases are transferred to other Atlanta area hospitals. Permission will be sought by the hospital and attending private physician prior to surgery and/or treatment.

_____ _____
Signature of Student or Parent (If student is under the age of 18) **Date**

HEALTH CARE PROVIDER

Name_____Signature_____Date_____

Address_____ Phone (_____) _____

Student Health and Wellness Center 455 Lee Street SW, Suite 300A, Atlanta, GA 30310
Phone number: (404) 756-1241 Email: SHWCRequests@msm.edu
