

## Student Health Services Immunization/ Tuberculosis Screening Record

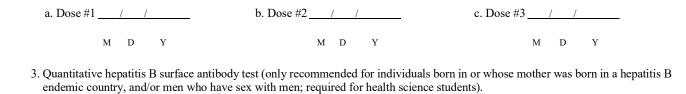
## PART I

Name						
	Last, First, M.I			Telephone Number		
Address	Street		City	State	Zip	
	Succi		City	State	Zip	
Date of Enrollment / /						
		M D Y				
Status: Part-time l	Full-time	Graduate	Undergraduate			
PART II: TO BE COMPLE	TED AND	SIGNED BY YOU	R HEALTH CARE	PROVIDER.		
All information must be in Engi	lish.					
A. MMR (MEASLES, MUN	MPS, RUBE	LLA) (Required)				
(Two doses required at least 28 days	apart for stude	nts born after 1956.)				
1. Dose 1 given at age 12 month	s or later		#1	/ /		
2. Dose 2 given at least 28 days	after first dose.		#2_	/ / M D Y		
OR positive antibody titer (blo						
B. MENINGOCOCCAL QU	U <b>ADRIVAL</b>	ENT(Required) P	olysaccharide accept	table		
(A, C, Y, W-135) 2 doses; 2 <sup>nd</sup> do		•	, and the second			
1. Quadrivalent conjugate	Č	C				
a. Dose #1 / /	b. D	ose #2 / / M D Y				
2. Quadrivalent polysacchari	de (acceptable	alternative if conjugate	not available).			
Date / / M D Y	` 1	<i>y 2</i>	,			
W D I						
C. TETANUS, DIPHTHER current throughout matr		SSIS (Required) (	Must be within the l	ast ten years and rem	ain	
Date of most recent booster d	ose:	/ / / D Y Tdap bo	Type of booster: Toster recommended for ag	Γd Tdap es 11-64 unless contraindice	ated	
		-				

## D. HEPATITIS B (Required)

mmunization (hepatitis B)  Dose #1/	b. Dose #2/_/	c. Dose #3/
M D Y  Adult formulation Child formulation	M D Y  Adult formulation Child formulation	M D Y  Adult formulation Child formulation
HepB-CpG (Heplisav-B)	HepB-CpG (Heplisav-B)	HepB-CpG (Heplisav-B)

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



<b>I</b>	VADICELLA (Dequired) (Degitive Varicella Titoria also accontable for compliance History of disease is not accontable)
L.	<b>VARICELLA</b> (Required) (Positive Varicella Titer is also acceptable for compliance. History of disease is not acceptable).
	1.Immunization



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

Date / / Result: Reactive Non-reactive

- **a.** Hepatitis A: \_\_/ \_ / \_ : \_ / \_ /
  \_\_ M \_ D \_ Y \_ M \_ D \_ Y **b.** Meningitis B: \_\_ / \_ / \_ : \_ / \_ /
  \_\_ M \_ D \_ Y \_ M \_ D \_ Y
- c. Influenza:  $\underline{\hspace{1cm}}/\hspace{1cm}/\hspace{1cm}/\hspace{1cm}$

H. TUBERCULOSIS (TB) RISK ASSESSMENT (to be completed by health care provider)  Tuberculin Skin Test (TST) (Required within past 12 months)	
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 abnormal	
<ul> <li>I. Medical Exemption:(Attach Verification by Healthcare Provider)</li> <li>□ Exemption on grounds of permanent medical contraindication</li> </ul>	
☐ 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 relunderstand that I am subject to exclusion in the event of a disease for which immunization is rea (Attach Notarized Affidavit)	_
<b>Notice:</b> Permission is hereby granted for Clark Atlanta University Health Services staff and/or their c to carry out indication medical and surgical treatment. Major surgery or illness cases are transferred to Atlanta area hospitals. Permission will be sought by the hospital and attending private physician prior and/or treatment.	o other
Signature of Student or Parent (If student is under the age of 18)  Date	
HEALTH CARE PROVIDER	
NameSignatureDa	nte
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