VIRGINIA COMMONWEALTH UNIVERSITY

VCU Health Sciences Certificate of Immunization

University Student Health Services
1300 West Broad Street, Suite 2200
P.O. Box 842022, Richmond, VA 23284-2022
Phone: (804) 827-8047 **Fax:** (804) 828-1093
Email: ushsimmuniz@vcu.edu **Web:** www.students.vcu.edu/health

Deadline for submission - Fall start: June 1 | Spring start: Nov. 1 | Summer start: April 1

The Office of the Senior Vice President for Health Sciences is responsible for crafting, interpreting, and revising this policy.

NAME _____ (Last / First / MI) Student "V" Number | | | | | | | | | |

ADDRESS _____ (Street Address / Apt. # / City / State / Zip Code)

DATE OF BIRTH _____ VCU EMAIL _____ PHONE NUMBER _____ (Including area code)

PROGRAM ACCEPTED INTO ☐ Allied Health ☐ Dentistry ☐ Medical ☐ Pharmacy ☐ Nursing

REQUIRED Immunizations

Hepatitis B #1 _____ #2 _____ #3 _____

OR **Hepatitis A/B** #1 _____ #2 _____ #3 _____

AND Serological confirmation of immunity. **Attach copy Hepatits B Surface Antibody Quantitative lab report.** If titer is negative after initial Hepatitis B series, contact University Student Health Services for recommendations on re-vaccination.

Influenza #1 _____ Required annually.

MMR (Measles, Mumps, Rubella) #1 _____ after first birthday
#2 _____ ≥ 28 days apart

OR Serological confirmation of immunity. **Attach copy of quantitative lab report.**

Meningococcal #1 _____ #2 _____

OR signed waiver.

Polio #1 _____ #2 _____ #3 _____ #4 _____
Primary series IPV or OPV. Required for students 18 and younger OR from high risk countries including Afghanistan AND Pakistan. Documentation may be required for clinical rotation sites.

TdaP (Tetanus, diphtheria, pertussis) #1 _____ **Td** (Tetanus, diphtheria) _____

Documentation of a TdaP since 2005, plus a current TdaP or Td.

Tuberculosis Complete Tuberculosis Screening/Testing information on the next page.

Varicella (Chicken Pox) #1 _____ #2 _____

OR date of disease _____ **AND** serological confirmation of immunity. **Attach copy of quantitative lab report** (Titer is not required if 2 does of vaccine spaced ≥ 28 days apart).

Meningitis Vaccine Waiver: I have reviewed information on the risk associated with meningococcal disease, availability and effectiveness of any vaccine against meningococcal disease *http://www.students.vcu.edu/media/student-affairs/ushs/docs/SHS1415-24CertificateofImmunization4.pdf* and I choose not to be vaccinated against meningococcal disease.

Signature of Student or Parent/Legal Guardian _____ Date _____

RECOMMENDED Immunizations

DPT (Primary Series Diphtheria, Pertussis, Tetanus) #1 _____ #2 _____ #3 _____ #4 _____ #5 _____

Hepatitis A #1 _____ #2 _____

HPV Vaccine #1 _____ #2 _____ #3 _____ ☐ Gardasil ☐ Cervarix

I have reviewed the Immunization and Tuberculosis information.

Health Care Provider (printed) _____ **Health Care Provider Signature** _____

Date _____ **Phone** _____

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Tuberculosis Testing/Screening

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NAME_____ DATE OF BIRTH _____

Student "V" Number

REQUIRED: Newly enrolled students **MUST** undergo a two-step Tuberculin skin test (TST) **OR** have one Interferon Gamma Release Assay Test (IGRA). All testing and X-Rays must be done in the USA and during the following time frames prior to semester start - Fall start: Jan. 1-June 1 | Spring start: May 1-Nov. 1 | Summer start: Oct. 1-April 1. Annual tuberculosis testing thereafter per program requirements.

A. Two-Step TST

Tests must be done at least seven days apart but no more than 30 days between first and second TST placement or series must be repeated.

Test 1: Date placed: _____ Date read:_____ Result: _____ mm _____ positive _____negative

Test 2: Date placed: _____ Date read:_____ Result: _____ mm _____ positive _____negative

B. IGRA

Date performed: _____ Result: _____ _____positive _____negative (Attach copy of lab report)

IGRA = Quantiferon Gold or T-Spot. Indeterminate or Borderline results are not acceptable. Repeat test or administer Two-step TST.

C. History of a prior Positive TST or IGRA

Date of Positive:_____ Result:_____ mm or attach IGRA report

TB Symptom Survey (Check all that apply)

_____ None _____ Cough > 3 weeks with or without sputum production _____ Coughing up blood

_____ Unexplained fever _____ Poor appetite _____ Unexplained weight loss _____ Night sweats _____ Fatigue

If yes to any question, please explain further_____

_____

D. Chest X-Ray

Required **ONLY** if POSITIVE TST or POSITIVE IGRA. Chest X-ray must be after positive TST/IGRA and within six months of semester start date - Fall: Aug. 1 | Spring: Dec. 1 | Summer: May 1. A negative chest x-ray is not a substitute for tuberculosis testing. Attach copy of x-ray report.

E. Treatment for TB disease or Latent TB Infection

Dates of treatment regimen: _____ to _____ (attach documentation)

I have reviewed the Immunization and Tuberculosis information.

Health Care Provider (printed) _____ **Health Care Provider Signature** _____

Date_____ **Phone**_____

For up-to-date vaccine information and recommendations for healthcare workers, visit http://www.cdc.gov/vaccines/adults/rec-vac/hcw.html
This form and any attachments will be used for data entry purposes only and will be destroyed upon completion of data entry. Please retain a copy for your records.

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Medical Exemption

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NAME_____ DATE OF BIRTH _____

Student "V" Number

As specified in the Code of Virginia § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____

_____

_____

_____

_____

_____

DTP/DTaP/Tdap ☐ DT/Td ☐ OPV/IPV ☐ Hib ☐ Pneum ☐ Measles ☐

Rubella ☐ Mumps ☐ HBV ☐ Varicella ☐ Meningococcal ☐

This contraindication is permanent ☐ or temporary ☐ and expected to preclude immunizations until _____ .
month/day/year

_____

Signature of Medical Provider or Health Department Official Date