



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

Certificate of Immunization

All full-time students are required by the Code of Virginia (Section 23-7.5) to provide documentation of their immunization by a licensed health professional. If you are unable to provide appropriate documentation, vaccines may be repeated. A registration hold for the upcoming semester will be placed if all required immunizations are not up-to-date.

Name: Last First MI Date of birth:

Address:

Born in the USA? Yes No If no, country of birth: Country of Residence:

Student V#: Email: Cell #:

Health Sciences Student? Yes - Please complete the VCU Health Sciences Certificate of Immunization found at http://www.students.vcu.edu/media/student-affairs/ushs/docs/SHS1516-02Ammendments.pdf. Please call the immunization department if unsure which form to complete.

To be completed and signed by a licensed health-care provider

Any attached documents in a language other than English must be translated into English by the health care provider.

Form containing immunization requirements and tracking fields. Includes sections for Tuberculosis Screening, IMMUNIZATIONS (Diphtheria, Hepatitis A/B, Human Papillomavirus, Meningococcal, Measles, Polio, Tetanus, Varicella), and a signature line for the Health Care Provider or Health Department.

Health Care Provider or Health Department Signature

Phone Number

Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Student V# \_\_\_\_\_

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**For treatment of students age 17 years and younger**

The law requires that parental permission be obtained in order to provide medical or surgical care to minors. This consent form should be signed by the parents so that medical care may be carried out promptly without unnecessary delays. I hereby authorize the physicians, clinicians, and staff nurses of VCU Student Health Services to examine, interview, test and, if necessary, treat my son/daughter as they deem advisable.

 \_\_\_\_\_  
 Signature of Parent/Legal Guardian

 \_\_\_\_\_  
 Date

**Hepatitis B Vaccine Waiver**

 (review prior to signing at  
<http://www.students.vcu.edu/media/student-affairs/ushs/docs/SHS1516-02CertificateofImmunization.pdf>)

I have read and reviewed information on the risk associated with hepatitis B disease, availability and effectiveness of any vaccine against hepatitis B disease and I choose not to be vaccinated against hepatitis B disease.

 \_\_\_\_\_  
 Signature of Student or Parent/Legal Guardian

 \_\_\_\_\_  
 Date

**Meningococcal Vaccine Waiver**

 (review prior to signing at  
<http://www.students.vcu.edu/media/student-affairs/ushs/docs/SHS1516-02CertificateofImmunization.pdf>)

I have read and reviewed information on the risk associated with meningococcal disease, availability and effectiveness of any vaccine against meningococcal disease and I choose not to be vaccinated against meningococcal disease.

 \_\_\_\_\_  
 Signature of Student or Parent/Legal Guardian

 \_\_\_\_\_  
 Date

**Religious Exemption**

Any student who objects on the grounds that administration of immunizing agents conflicts with his or her religious tenets or practices shall be exempt from the immunization requirements unless an emergency or epidemic of disease has been declared by the Board of Health. An affidavit of religious exemption must be submitted on a Certificate of Religious Exemption (Form CRE-1) found at [http://www.vdh.virginia.gov/epidemiology/Immunization/documents/SchoolRegulations/cre\\_1.pdf](http://www.vdh.virginia.gov/epidemiology/Immunization/documents/SchoolRegulations/cre_1.pdf)

**Medical Exemption**

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: Date (Mo., Day, Yr.): \_\_\_\_\_

 \_\_\_\_\_  
 Signature of Medical Provider/Health Department Official

 \_\_\_\_\_  
 Date

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ STUDENT V#: \_\_\_\_\_

## Tuberculosis Screening

The Centers for Disease Control and the U.S. Public Health Service recommend that tuberculosis testing be performed on ALL individuals who may be at increased risk of tuberculosis disease. For more information, visit <http://www.acha.org> or refer to the CDC's Core Curriculum on Tuberculosis available at <http://www.cdc.gov/nchstp/tb/pubs/corecurr/>.

1. Have you had a prior positive TB test? (If yes, you **must** complete Page 3).  Yes  No
2. Have you ever been a close contact with persons known or suspected to have active TB disease?  Yes  No
3. Have you been a resident and/or employee in high risk settings such as long-term care facilities, homeless shelters or correctional facilities?  Yes  No
4. Have you been a healthcare worker?  Yes  No
5. Have you ever injected illegal drugs?  Yes  No
6. Do you have signs or symptoms of active TB disease: unexplained fever, weight loss, loss of appetite, night sweats, persistent cough for more than 3 weeks, cough with production of bloody sputum?  Yes  No
7. Do you have a clinical condition such as HIV, diabetes, cancer, kidney disease, silicosis, leukemia or lymphoma, chronic malabsorption syndromes, removal of part of your stomach or have been on prolonged corticosteroid or immunosuppressive therapy?  Yes  No
8. Were you born in a country listed below and lived there for three (3) months or more? \_\_\_\_\_  Yes  No
9. Have you lived in or visited any country listed below for three (3) months or more? \_\_\_\_\_  Yes  No

Afghanistan	Republic)	Kenya	Nicaragua	Suriname
Algeria	Cote d'Ivoire	Kiribati	Niger	Swaziland
Angola	Djibouti	Kuwait	Nigeria	Syrian Arab Republic *
Argentina	Dominican Republic	Kyrgyzstan	Northern Mariana	Tajikistan
Armenia	Ecuador	Korea (North and South)	Islands	Thailand
Azerbaijan	El Salvador	Lao	Pakistan	Timor-Leste
Bangladesh	Equatorial Guinea	Latvia	Palau	Togo
Belarus	Eritrea	Lesotho	Panama	Tunisia
Belize	Ethiopia	Liberia	Papua New Guinea	Turkmenistan
Benin	Fiji	Lithuania	Paraguay	Tuvalu
Bhutan	French Polynesia	Libya *	Peru	Tanzania (United
Bolivia	Gabon	Madagascar	Philippines	Republic)
Bosnia and Herzegovina	Gambia	Malawi	Portugal	Uganda
Botswana	Georgia	Malaysia	Qatar	Ukraine
Brazil	Ghana	Maldives	Romania	Uruguay
Brunei Darussalam	Guam	Mali	Russian Federation	Uzbekistan
Bulgaria	Guatemala	Marshall Islands	Rwanda	Vanuatu
Burkina Faso	Guinea	Mauritania	Sao Tome and Principe	Venezuela
Burundi	Guinea-Bissau	Mexico *	Senegal	Viet Nam
Burma (Myanmar)	Guyana	Micronesia (Federal	Serbia	Wallis and Futuna
Cabo Verde	Haiti	States)	Sierra Leone	Islands
Cambodia	Honduras	Moldova (Republic of)	Singapore	Yemen
Cameroon	India	Mongolia	Solomon Islands	Zambia
Central African Republic	Indonesia	Morocco	Somalia	Zimbabwe
Chad	Iran *(Islamic Republic	Mozambique	South Africa	
China	of)	Myanmar (Burma)	South Sudan	
Colombia	Iraq	Nauru	Sri Lanka	
Congo (Democratic	Kazakhstan	Nepal	Sudan	

I have answered "YES" to 1 or more of the above questions. A TB test is required. Submit results of a TB test or IGRA done in the United States within the past year.

I have answered "NO" to ALL of the above questions. No TB test is required.

Signature of Student or Parent/Legal Guardian

Date

Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Student V# \_\_\_\_\_

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## TUBERCULOSIS SYMPTOM SURVEY

For students with POSITIVE Tuberculin skin tests or IGRA performed in the United States  
**Complete this form if you have ever had a positive TB test.**

**Positive TB Test** Date \_\_\_\_\_ Induration \_\_\_\_\_ **OR Positive IGRA** Date \_\_\_\_\_  
**Enclose copy of positive TB test documentation** **Enclose copy of report; IGRA =**  
**Quantiferon Gold or T-Spot**

**Last Chest X-Ray** Date \_\_\_\_\_ Result \_\_\_\_\_  
**Enclose copy of most recent chest x-ray report.**

Have you taken medication for TB infection Yes  No  • If Yes, Medication \_\_\_\_\_ Date began \_\_\_\_\_  
Date completed \_\_\_\_\_

Do you currently have any of the following symptoms?

1. Cough lasting more than three weeks? Yes  No
2. Unexplained weight loss? Yes  No
3. Loss of appetite? Yes  No
4. Unexplained fatigue? Yes  No
5. Fever and night sweats? Yes  No
6. Blood tinged sputum production? Yes  No

If "Yes" to any question, please explain further, including date of onset and any treatment.

I am aware that the six symptoms listed above are possible signs/symptoms of active tuberculosis disease that I should promptly report to my healthcare provider.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

### For Healthcare Provider Use:

I have reviewed the above information and agree with the student's information as indicated above.

Healthcare Provider Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

## Waiver Information for Meningococcal Disease & Hepatitis B

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*Please read the following information on Meningococcal Disease and Hepatitis B before signing the waiver on the Certificate of Immunization.*

### Hepatitis B

Hepatitis B is a potentially fatal disease that attacks the liver. The virus can cause short-term (acute) illness that leads to loss of appetite, tiredness, diarrhea and vomiting, jaundice (yellow skin or eyes) and pain in muscles, joints and stomach. Many people have no symptoms with the illness. It can also cause long-term (chronic) illness that leads to liver damage, liver cancer and death.

According to the Centers for Disease Control, about 800,000 – 1.4 million people in the U.S. have chronic Hepatitis B infection. Each year approximately 40,000 people, mostly young adults, become infected with Hepatitis B virus. Young adults are more likely to contract Hepatitis B infection due to greater likelihood of high-risk behaviors such as multiple sexual partners.

Approximately 3,000 people die from chronic Hepatitis B infection annually. It is spread through contact with blood and body fluids of an infected person, such as having unprotected sex with an infected person or sharing needles when injecting illegal drugs. Unvaccinated *health-science students* are at risk of contracting Hepatitis B through an accidental occupational needle stick exposure.

There are several ways to prevent Hepatitis B infections including avoiding risky behavior, screening pregnant women and vaccination. Vaccine is the best prevention. The vaccine series typically consists of three injections given over a six month period, which are available through your private health care provider, health department or University Student Health Services.

*Remember: Completion of the vaccine series is needed for protection against Hepatitis B disease.*

### Meningococcal Disease

Meningococcal disease is the leading cause of bacterial meningitis in children 2-18 years old in the U.S. Meningitis is an infection of the brain and spinal cord coverings. Meningococcal disease can also cause blood infections. According to the Centers for Disease Control, about 2,600 people get meningococcal disease each year in the U.S. Of these cases, 10-15% die and of those who live, another 10% may require limb amputation, develop kidney failure or brain damage, become deaf, suffer seizures or strokes.

College freshmen, particularly those who live in dormitories, have a slightly increased risk of getting meningococcal disease as illustrated by a case rate of 5.4/100,000 18-23 year olds as opposed to a case rate of 1.4/100,000 18-23 year olds in the general population.

Meningococcal vaccine is effective in preventing four types of meningococcal disease including two of the three most commonly occurring types in the U.S. The vaccine is 85-100% effective in preventing serotype A and C in older children and adults. It does not however protect against serotype B which causes one third of cases in patients 15-24 years. Therefore, in the event of an outbreak, even previously immunized individuals should contact their health care providers.

ACIP recommends routine vaccination of persons with meningococcal conjugate at age 11 or 12 years with a booster dose at age 16. Persons who receive their first meningococcal conjugate vaccine at or after 16 years do not need a booster dose. Routine vaccination of healthy persons 21 years or older who are not at increased risk of exposure to N. Meningitidis is not recommended.

The vaccine is available through your private healthcare provider, most local health departments and University Student Health Services.