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
Web: www.students.vcu.edu/health

All full-time students are required by the Code of Virginia (Section 23-7.5) to provide documentation of their immunizations 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.
Deadline for submission within 30 days of semester start.

Name:_____ Date of birth: _____
Last First MI

Address:_____

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

Student V#:_____ Email: _____ Cell #: _____

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.

®	= REQUIRED
®	**Tuberculosis Screening** All students regardless of enrollment status are required to complete the tuberculosis screening form on page 3.
	IMMUNIZATIONS
	Diphtheria, Pertussis, Tetanus (DPT) Student has received _____ doses. Last dose given on _____.
	Hepatitis A ① _____ ② _____
®	**Hepatitis B** ① _____ ② _____ ③ _____ **OR** Serological confirmation of immunity. **Attach copy of lab result.** **OR** Waiver signed. **or Hep A/B** ① _____ ② _____ ③ _____
	HPV ① _____ ② _____ ③ _____ HPV4 ☐ HPV9 ☐
®	**Meningococcal vaccine** ① _____ ***One dose required after 16th birthday.** **OR** Waiver signed. MCV4 ☐ MPS4 ☐
	Meningococcal Group B ① _____ ② _____ ③ _____ ☐ Bexsero ☐ Trumenba
®	**Measles, Mumps, Rubella (MMR)** after first birthday ① _____ ② _____ **OR** serological confirmation of immunity to measles, mumps and rubella. **Attach copy of lab result.**
®	**Polio (IPV or OPV)** ① _____ ② _____ ③ _____ ④ _____ *Required for 18 and under OR from countries of high risk including Afghanistan and Pakistan.
®	**Tetanus, diphtheria, pertussis (Tdap) Required** within 10 years _____ **OR Tetanus, diphtheria (Td)** within 10 years _____
	Varicella (Chicken Pox) **Vaccines** ① _____ ② _____ **OR Date of Disease** _____

Health Care Provider or Health Department Signature **Date** **Phone**

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. Revised 5/2017

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

Meningococcal Vaccine Waiver

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 online by visiting students.vcu.edu/health, under the Immunizations tab, and then under the Forms & Documents page.

Hepatitis B Vaccine Waiver

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

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 Form

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

☐ **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

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Name _____
Date of Birth _____
Student V# _____

TUBERCULOSIS SYMPTOM SURVEY

Complete IF history of POSITIVE Tuberculin skin test or IGRA (T-spot or QFT).

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 _____

- ☐ INH
- ☐ Rifampin
- ☐ 3HTP (12 week DOT)

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.

_____

_____

LTBI treatment discussed ☐
LTBI brochure offered ☐

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 _____

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Waiver Information for Meningococcal Disease & Hepatitis B

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 stokes.

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. Meningitides is not recommended.

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