**VCU Health Sciences Certificate of Immunization**

Deadline for submission within 30 days of program start.
The Office of the Senior Vice President for Health Sciences is responsible for crafting, interpreting, and revising this policy.

**NAME**

last name, first name, middle initial

**ADDRESS**

street address, apt. #, city, state, zip code

**DATE OF BIRTH**

**VCU EMAIL**

**PHONE NUMBER**

(including area code)

**PROGRAM**

- Allied Health
- Dentistry
- Medical
- Pharmacy
- Nursing

**REQUIRED Immunizations**

**Hepatitis B**

#1
#2
#3

**OR Hepatitis A/B**

#1
#2
#3

**Influenza**

#1

Required annually.

**MMR**

(Chicken Pox)

#1

after first birthday

#2

≥ 28 days apart

**MMR**

(Mumps, Measles, Rubella)

#1

after first birthday

#2

≥ 28 days apart

**Meningococcal**

#1

after 16th birthday

**Meningitis Vaccine Waiver:** I have 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 ______________

**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
#2
#3

Complete Tuberculosis Screening/Testing information on the next page.

**Tuberculosis**

**Varicella**

(Chicken Pox)

#1
#2

**RECOMMENDED Immunizations**

**DPT**

(Primary Series Diphtheria, Pertussis, Tetanus)

#1
#2
#3
#4
#5

**Hepatitis A**

#1
#2

**HPV Vaccine**

#1
#2
#3

**AND Serological confirmation of immunity. Attach copy of Hepatitis 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.

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

**OR signed waiver.**

**Documentation of a Tdap since 2005, plus a current Tdap or Td within last 10 years. Some clinical rotations may require an adult dose of Tdap.**

**I have reviewed the Immunization and Tuberculosis information.**

**Health Care Provider (printed)**

________________________

**Health Care Provider Signature**

________________________

**Date**

________________________

**Phone**

________________________
Tuberculosis Testing/Screening

Deadline for submission within 30 days of program start.

NAME ___________________________ DATE OF BIRTH __________________

Student "V" Number

REQUIRED: Newly enrolled students MUST undergo a two-step Tuberculin skin test (TST) OR have 1 Interferon Gamma Release Assay Test (IGRA). All testing and X-Rays must be done in the USA. Annual tuberculosis testing thereafter per program requirements.

A. Two-Step TST
Tests must be done at least 7 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 (QFT Gold or T-Spot)

Date performed: _________ Result date: _______  _____ positive _____ negative

Indeterminate or Borderline results are not acceptable. Repeat test or administer Two-step TST.

C. History of a prior Positive TST or IGRA (QFT Gold or T-Spot)

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 6 months of semester start date. 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

☐INH  ☐Rifampin  ☐3HTP (12 week DOT)

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.