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.

University Student Health Services
MCV Campus
1000 E. Marshall St., Room 305, Richmond VA, 23298-0201
Phone: (804) 828-9220 **Fax:** (804) 828-3181
Web: www.students.vcu.edu/health

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 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.

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 _____ after 16th birthday

OR signed waiver.

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 _____ **Td** _____ (Tetanus, diphtheria)

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.

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 doses of vaccine spaced ≥ 28 days apart).

RECOMMENDED Immunizations

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

Hepatitis A #1 _____ #2 _____

HPV Vaccine #1 _____ #2 _____ #3 _____

I have reviewed the Immunization and Tuberculosis information.

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

Date _____ **Phone** _____

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 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 **Attach copy of lab report**

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.