VCU VIRGINIA COMMONWEALTH UNIVERSITY

Certificate of Immunization

University Student Health Services
P.O. Box 842022, Richmond, VA 23284-2022
Phone: (804) 827-8047 **Fax:** (804) 828-1093
Email: ushs-immuniz@vcu.edu
Web: www.students.vcu.edu/health

NAME: Last First

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.
All students regardless of enrollment status are required to complete the tuberculosis (TB) screening section of this form.

Name: _____ (Last) _____ (First) _____ (MI)

Student ID: _____ **Date of birth:** _____

US Citizen born in the USA? ☐ yes ☐ no **If no, country of birth:** _____ **Year entered U.S.:** _____

Address: _____

Email: _____

Please check if you will be enrolled on the MCV (Medical) Campus ☐

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.

	IMMUNIZATIONS	DATES ADMINISTERED
	Diphtheria, tetanus, pertussis (DPT)	has received_____doses, last dose given ___|___|___ M D Y
®	**Tetanus, diphtheria, pertussis (Tdap) Required** within 10 years	___|___|___ M D Y **OR Tetanus, diphtheria (Td)** within 10 years ___|___|___ M D Y
	Polio IPV or OPV	has received_____doses, last dose given ___|___|___ M D Y **OR** Serological confirmation of immunity. **Attach copy of lab result.**
	Hepatitis A	① _____ ② _____
®	**Hepatitis B or combined Hep A/B**	① ___|___|___ ② ___|___|___ ③ ___|___|___ M D Y **OR** Serological confirmation of immunity. **Attach copy of lab result.** **OR** Waiver signed.
®	**Measles, mumps, rubella (MMR)** after first birthday and 4/71.	① ___|___|___ ② ___|___|___ M D Y **OR** serological confirmation of immunity to measles, mumps and rubella. **Attach copy of lab result.**
	Human Papillomavirus	① ___|___|___ ② ___|___|___ ③ ___|___|___ M D Y ☐ Gardasil ☐ Other
®	**Meningococcal vaccine**	① ___|___|___ ② ___|___|___ M D Y **OR** Waiver signed. ☐ MCV4 given ☐ MPSV4 given
®	**Tuberculosis Screening** (In the United States within the last year. See the back of this form.)	**1. Not at high-risk for TB exposure** No skin test placed. **2. History of prior positive TB skin test** Complete attached Tuberculosis Assessment Form and **attach copy of chest x-ray report.** **3. At high risk for TB exposure or entering the health professions** TB skin test placed Date placed _____ Date read _____ Interpretation _____pos_____neg _____mm induration (if none, write 0) or IGRA attach copy of lab result **If positive: complete attached Tuberculosis Assessment Form**
	Varicella (Chicken Pox) Strongly recommended	Date of Disease ___|___|___ M D Y **AND** Serological confirmation of immunity. **Attach copy of lab result.** **OR vaccines** ① ___|___|___ M D Y ② ___|___|___ M D Y
®	**= Required**	

Signature of Health Care Provider

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.

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 such procedures 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 or Guardian Date

Hepatitis B Vaccine Waiver

(see attached information prior to signing)

I have 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 Legal Guardian Date

Meningitis Vaccine Waiver

(see attached information prior to signing)

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 Legal Guardian Date

Medical Exemption:

___DPT ___Td ___IPV ___Measles ___Rubella ___Mumps ___Meningococcal ___Hepatitis B ___Varicella ___Tdap

As specified in Section 22.1-271.2,C.(II) of the Code, I certify that administration of the vaccine(s) designated above would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because

This contraindication is ____ permanent (or) ____ temporary and expected to preclude immunization until ____|____|____.

Signature of Physician or Health Department Official Date

VCU VIRGINIA COMMONWEALTH UNIVERSITY
Immunizations

Immunization Coordinator
1300 W. Broad St., suite 2200
P.O. Box 842022, Richmond, VA 23284-2022
Phone: (804) 828-8828 **Fax:** (804) 828-1093

Fulfill immunization requirements now to prevent a registration hold

Tuberculosis Risk Assessment

The U.S. Public Health Service and the Centers for Disease Control recommend that tuberculosis skin testing be performed on all individuals who may be at increased risk of tuberculosis disease.

If any of the following statements are applicable to you, please submit the results of a tuberculosis skin test (TST) performed in the U.S. **within the last year.**

- **Health-care worker or a student entering a health-care profession.**
- Unexplained weight loss.
- Unexplained night sweats.
- Unexplained persistent cough for more than three weeks.
- Cough with the production of bloody sputum.
- Close contact with a known case of active tuberculosis.
- Use of illegal injected drugs.
- HIV infection.
- Resident or employee of a nursing home, homeless shelter or correctional facility.
- Cancer.
- Diabetes.
- Kidney disease.
- Immunosuppressive therapy.
- Removal of part of your stomach.
- Silicosis.
- You have lived in the United States for **less than five years** and were born in a country **EXCEPT**:

Albania
America Samoa
Andorra
Antigua and Barbuda
Australia
Austria
Barbados
Belgium
Bermuda
British Virgin Islands
Canada
Cayman Islands
Chile
Cook Islands
Costa Rica
Cuba
Cyprus
Czech Republic
Denmark
Dominica
Finland
France
Germany
Greece
Grenada
Hungary
Iceland
Ireland
Israel
Italy
Jamaica
Jordan
Lebanon
Libyan Arab Jamahiriya
Luxembourg
Malta
Monaco
Montserrat
Netherlands
Netherlands Antilles
New Zealand
Norway
Puerto Rico
Saint Kitts and Nevis
St. Lucia
Samoa
San Marino
Slovakia
Slovenia
Sweden
Switzerland
Trinidad and Tobago
Turks and Caicos Islands
United Arab Emirates
United Kingdom
United States of America
U.S. Virgin Islands

Immunization Requirements

Ⓡ Tetanus / Diphtheria
- Primary immunization series, including month/day/year of each dose.
  – Documentation requested.
- Tdap (preferred) to replace a single dose of Td booster for immunizations. given after age 11 and within the last ten years.
- Tetanus/diphtheria booster (Td) (month/day/year) within the past ten years.
  – Documentation required.

Polio
- Documentation of primary immunization series requested.

Hepatitis A Vaccine
- Documentation of series completion requested.
- Two doses of Adult/Pediatric Hepatitis A vaccine given 6-12 months apart.

Ⓡ Hepatitis B Vaccine
- Series of three vaccines given over a six month period **or** signed waiver.
  – Combined hep A / hep B vaccination series may fulfill this requirement.

Human Papillomavirus Vaccine
- Documentation requested.
- See AICP recommendations.

Ⓡ MMR (Measles, Mumps, Rubella combination vaccine)
- Two doses both given after the first birthday, after April 1971 and at least one month apart will fulfill the measles, mumps, rubella requirement or serological confirmation of immunity to measles, mumps and rubella.

OR

two measles vaccines, both given after one year of age after 1967.

AND

two mumps vaccines, both given after one year of age after 1967.

AND

two rubella vaccines, both given after one year of age after 1969.

Ⓡ Meningococcal Vaccine
- Vaccine or signed waiver required. One or two doses. If the first dose is given at 11 - 15 years, give one booster dose, preferably at 16 - 18 years. Persons that receive their first dose of Meningococcal vaccine at or after age 16 do not need a booster dose. Routine vaccination of healthy persons who are not at increased risk for exposure to N. Meningitides is not recommended after age 21 years.

Ⓡ Tuberculosis Screening
- Tuberculosis screening is required of all entering students; however, not all students will require placement of the TB skin test. See Tuberculosis Risk Assessment for clarification.

Varicella (Chicken Pox)
- Strongly recommended for all students without history of the disease or without age appropriate immunization or with a negative antibody titer.
- Two doses of vaccine given four (4) weeks apart or serological confirmation of immunity is strongly recommended.

Ⓡ = Required

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) which may be obtained at any local health department, school division superintendent's office or local department of social services.

VCU VIRGINIA COMMONWEALTH UNIVERSITY
University Student Health Services
Division of Student Affairs

Immunization Coordinator
1300 W. Broad St., suite 2200
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Phone: (804) 828-8828 **Fax:** (804) 828-1093

TUBERCULOSIS ASSESSMENT

For students with POSITIVE Tuberculin skin tests

Name _____

Date of birth _____ Student ID# _____

Date of positive TB test_____Induration _____

Last Chest X-ray: Date _____ Result _____ *Enclose copy of report*

Have you previously completed a course of medicine for TB infection? Yes/No

If yes, what medicine was taken and for how long? _____

Are you currently taking medication for TB infection? Yes/No

If yes, when did you start the medicine? _____

Do you currently have any of the following symptoms? (please circle yes or no)

1. Cough lasting greater than two 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 promply report to my healthcare provider.

_____ _____

Student Signature Date

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Waiver Information for Meningitis & Hepatitis B

Please read the following information on Meningitis 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 Meningitis

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 health-care provider, most local health departments and University Student Health Services.