Immunization Form

Student Health Services
LOCATION 200 Georgia Ave. • **ADDRESS** 1500 N. Patterson St. • Valdosta, GA 31698–0175
PHONE 229.333.5886 • **FAX** 229.249.2791 • **WEB** www.valdosta.edu/health

ALL FORMS MUST BE COMPLETED IN ENGLISH

Date _____/_____/_____

ACCEPTED TERM/YEAR _____/_____

You can submit this form by uploading it as a PDF to the Health Center's Online Portal, located at **www.valdosta.edu/health**. Questions can be emailed to **immunizations@valdosta.edu** or you may call us at **229.219.3203.**

NAME _____ VSU STUDENT ID NUMBER _____

ADDRESS _____

DATE OF BIRTH _____ AGE _____ PHONE _____

CERTIFICATE OF IMMUNIZATIONS (REQUIRED)

REQUIRED IMMUNIZATIONS	REQUIREMENT		REQUIRED FOR:
MMR (Measles, Mumps, Rubella) combined shot	• 2 Doses	#1 _____/_____/_____ #2 _____/_____/_____	• **Students born in 1957 or later and all foreign born students, regardless of year born**
OR • Measles (Rubella)	**OR** • 2 Doses • **or Titer**	#1 _____/_____/_____ #2 _____/_____/_____ _____/_____/_____	• **Students born in 1957 or later** • *Attach titer results with lab values. If antibody titer does not indicate immunity, injection series required.*
and • Mumps	**and** • 2 Doses • **or Titer**	#1 _____/_____/_____ #2 _____/_____/_____ _____/_____/_____	• **Students born in 1957 or later** • *Attach titer results with lab values. If antibody titer does not indicate immunity, injection series required.*
and • Rubella (German Measles)	**and** • 1 Dose • **or Titer**	#1 _____/_____/_____ _____/_____/_____	• **Students born in 1957 or later** • *Attach titer results with lab values. If antibody titer does not indicate immunity, injection series required.*
Varicella (Chicken Pox)	• 2 Doses • **or** History of chicken pox (verified by MD) **or** shingles • **or Titer**	#1 _____/_____/_____ #2 _____/_____/_____ _____/_____/_____ _____/_____/_____	• **All *U.S. born* students born in 1980 or later and *all foreign* born students, regardless of year born** • *Attach titer results with lab values. If antibody titer does not indicate immunity, injection series required.*
Tetanus-Diphtheria-Pertussis (Whooping Cough) or Td booster	• Tdap **(Required)** • Td Booster	_____/_____/_____ _____/_____/_____	• **All students must have one dose of Tdap and One Td booster if it has been ≥10 years after receiving Tdap** *(A single dose of Tdap is recommended to replace a single dose of Td.)*
Hepatitis B	• 3 Dose series • **or Titer**	#1 _____/_____/_____ #2 _____/_____/_____ #3 _____/_____/_____ _____/_____/_____	• **All students 18 years of age and <u>under</u> at matriculation** • *Attach titer results with lab values. If antibody titer does not indicate immunity, injection series required.*
Tuberculosis screening	• **All students**, must complete TB screening questionnaire		• **If the answer to any of the TB screening questions is "YES", must complete TB Risk Assessment, Part II – to be completed by a physician**

RECOMMENDED IMMUNIZATIONS

Hepatitis A	2 Doses	#1 _____/_____/_____	#2 _____/_____/_____	
Human Papillomavirus (HPV-Gardasil)	3 Doses	#1 _____/_____/_____	#2 _____/_____/_____	#3 _____/_____/_____
Meningitis (A,C,Y,W)		#1 _____/_____/_____	#2 _____/_____/_____	
Meningitis B	2 or 3 Doses	#1 _____/_____/_____	#2 _____/_____/_____	#3 _____/_____/_____
Other vaccines:	_____	_____/_____/_____	_____	_____/_____/_____

REQUEST FOR EXEMPTION

PERMANENT OR TEMPORARY IMMUNIZATION EXEMPTION (check appropriate area)

❑ This student is exempt from above immunizations on the ground of permanent medical contraindication.

❑ This student is temporarily exempt from the above immunization until _____/_____/_____ .

Exemptions and Waivers — In the event of an outbreak, exempted persons may be subject to exclusion from school and to quarantine, until proof of vaccination(s) is provided. If you begin taking courses **"on campus"**, you will no longer be "exempt" and will be required to submit your immunization form.

If religious exemption is required, please sign here — _____
STUDENT SIGNATURE

If you declare that you are enrolling in **ONLY** courses offered by distance learning, please sign here — _____
STUDENT SIGNATURE

If you are living on campus, declining to be immunized against Meningococcal disease, and requesting a wavier for not obtaining the Meningitis vaccine, please sign here — _____ and complete the **Meningococcal Vaccine Declination Form.**
STUDENT SIGNATURE

REQUIRED SIGNATURE OF PHYSICIAN OR HEALTH FACILITY

_____ (_____) _____ – _____
NAME PHONE NUMBER

ADDRESS _____

_____ _____ / _____ / _____
SIGNATURE (PHYSICIAN OR HEALTHCARE FACILITY, PLEASE PRINT & SIGN BEFORE SUBMITTING) DATE

PHYSICIAN OR HEALTH FACILITY SIGNATURE IS REQUIRED ON THIS FORM.

Medical Entrance Form

Student Health Services
LOCATION 200 Georgia Ave. • **ADDRESS** 1500 N. Patterson St. • Valdosta, GA 31698–0175
PHONE 229.333.5886 • **FAX** 229.249.2791 • **WEB** www.valdosta.edu/health

ALL FORMS MUST BE COMPLETED IN ENGLISH

Date
_____/_____/_____

ACCEPTED TERM/YEAR
_____/_____

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SEMESTER BEGINNING | DATE | VSU STUDENT ID NUMBER | DATE OF BIRTH | AGE AT TIME OF APPLICATION

NAME (LAST, FIRST, MIDDLE)

ADDRESS | CITY | STATE | COUNTRY

ZIP CODE | (____) ____ – ____ CELL PHONE | EMAIL

****This information will remain confidential and will be utilized by Student Health Services personnel only.***

1. ALLERGIES (List all medication, food, insect or other known allergies below)

Do you receive allergy shots? ❑ YES ❑ NO If yes, please have your allergy records faxed to 229.249.2791 .

2. HOSPITALIZATION (List all prior hospitalizations, surgeries, and procedures)

3. MEDICATION (List all medications including doses that you are currently taking)

4. MEDICAL HISTORY

Are you now or have you been under the care of a physician for an ongoing illness/medical condition? ❑ **YES** ❑ **NO**
Do you have a chronic (long-lasting or persistent) medical condition that requires treatment or medication? ❑ **YES** ❑ **NO**
If yes, please have your physician fax a summary of your treatment to **229.249.2791** that includes the following:

- Condition being treated
- Type of medicine
- Physician's name, address and phone number

Please check all that apply

❑ Emphysema
❑ Tuberculosis
❑ Pneumonia
❑ Bronchitis
❑ Allergies
❑ Diabetes
❑ Cirrhosis
❑ Fractures
❑ Arthritis
❑ Thyroid Trouble
❑ Cardiovascular Disease
❑ Anemia
❑ Migraines
❑ Heart Disease
❑ Prostate Trouble
❑ Elevated Cholesterol
❑ Stroke
❑ Hepatitis A
❑ Osteoporosis
❑ Ulcerative Colitis
❑ Anxiety or Panic Disorder
❑ Asthma
❑ Hepatitis B
❑ Crohn's Disease
❑ Sickle Cell Disease
❑ Irritable Bowel Syndrome
❑ Ulcers
❑ Hepatitis C
❑ Cystic Fibrosis
❑ Gallbladder Disease
❑ Cancer
❑ Depression
❑ Venous Thrombosis
❑ High Blood Pressure
❑ Post-traumatic Stress Disorder
❑ Sexually Transmitted Infections
❑ Frequent Urinary Tract Infections
❑ Bleeding Disorder or Other Blood Disorders
❑ Alcohol/Substance Abuse Problem
❑ Other: _____

Do you have a living will, advanced directive, durable power of attorney for healthcare or physician order for life sustaining treatment? (If yes, submit with your medical records forms to Student Health Services.) ❑ **YES** ❑ **NO**

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Date
_____/_____/_____

ACCEPTED TERM/YEAR
_____/_____

5. AUTHORIZATION TO TREAT (If you are 18 years of age or **OVER**)

- The General Consent for treatment gives permission to personnel of Valdosta State University Health Services to perform a medical evaluation including obtaining a history, doing a physical exam, performing a diagnostic workup and providing treatment, including minimally invasive procedures such as venipuncture to draw blood, x-rays, and IV catheter insertion to administer medications or IV fluids.
- The patient has the right to refuse any treatment.
- A record of General Consent for Treatment will be stored in the patient's medical record.
- Duration of General Consent for Treatment has continuing force and effect until the patient revokes the consent.

I hereby authorize the physicians, physician assistants, and nurse practitioners of Valdosta State University Health Services and their agents or consultants, including those at area hospitals and/or Georgia Department of Public Health, to perform diagnostic and treatment procedures which in their judgment may be necessary while I am at Valdosta State University. I understand I am responsible for charges incurred.

_____ _____/_____/_____
PATIENT SIGNATURE DATE

6. AUTHORIZATION TO TREAT (If you are **UNDER** 18 years of age)

I hereby authorize the physicians, physician assistants, and nurse practitioners of Valdosta State University Health Services, and their agents or consultants, including those at area hospitals and/or Georgia Department of Public Health, to perform diagnostic and treatment procedures which in their judgment may be necessary while he/she attends Valdosta State University. I waive all claim to prior notification. I understand that every reasonable effort will be made to notify me in the event of a major illness or injury, or if the Valdosta State University Health Services physician feels it is necessary. I understand I am responsible for charges incurred.

_____ _____/_____/_____
PATIENT SIGNATURE DATE

_____ _____/_____/_____
SIGNATURE OF PARENT/GUARDIAN DATE

EMERGENCY CONTACT INFORMATION

_____ _____
NAME RELATIONSHIP

_____
ADDRESS

_____
CITY STATE COUNTRY ZIP CODE

(_____) _____ – _____ (_____) _____ – _____ _____
DAYTIME PHONE EVENING PHONE EMAIL

_____ _____
NAME RELATIONSHIP

_____
ADDRESS

_____
CITY STATE COUNTRY ZIP CODE

(_____) _____ – _____ (_____) _____ – _____ _____
DAYTIME PHONE EVENING PHONE EMAIL

PLEASE NOTE: RETURN THESE FORMS TO STUDENT HEALTH SERVICES ***PRIOR*** TO YOUR ORIENTATION DATE.

Students should keep a copy of these forms for their personal records.

_____ _____
NAME VSU STUDENT ID NUMBER

TB Screening & Risk Assessment Form

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Date _____/_____/_____

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NAME _____ STUDENT ID NUMBER _____

ADDRESS _____

DATE OF BIRTH _____ AGE _____ PHONE _____

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE (REQUIRED)

Complete this form and return to VSU Student Health Services prior to your orientation date. All forms must be completed prior to arriving on campus.

1. Have you ever had close contact with persons known or suspected to have active TB disease? ❑ Yes ❑ No
2. Were you born in one of the countries listed below that have a high incidence of active TB disease? (If YES, please CIRCLE the country, below) ❑ Yes ❑ No
3. Have you had frequent or prolonged visits to one or more countries listed below with a high prevalence of TB disease? (If YES, CHECK the countries, below) ❑ Yes ❑ No
4. Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ❑ Yes ❑ No
5. Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? ❑ Yes ❑ No
6. Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol? ❑ Yes ❑ No

If the answer is YES to any of the above screening questions, you must complete the TB Risk Assessment.

If you answered yes to any of the above questions, Valdosta State University requires that students complete a tuberculosis risk assessment by a physician or healthcare facility. This TB Risk Assessment must be completed no later than 30 days following the first day of the initial semester at Valdosta State University. The TB Risk Assessment may be completed at Student Health Services at Valdosta State University following the first day of classes during the initial enrolled semester.

****If the answer is NO to all of the above questions, you may sign and no further assessment is required.****

You may also mail this signed form to the VSU Student Health Services, 200 Georgia Ave., Valdosta, GA 31698 or fax to 229.249.2791.

_____ _____ / _____ / _____
SIGNATURE OF STUDENT DATE

OR Signature of parent/guardian if student is UNDER 18 years old

**List of countries:*

Afghanistan	Cambodia	French Polynesia	Kuwait	Myanmar	Rwanda	Togo
Algeria	Cameroon	Gabon	Kyrgyzstan	Namibia	St. Vincent & The Grenadines	Tokelau
Angola	Cape Verde	Gambia	Lao PDR	Nauru		Tonga
Anguilla	Central African Republic	Georgia	Latvia	Nepal	Sao Tome & Principe	Tunisia
Argentina	Chad	Ghana	Lesotho	New Caledonia	Saudi Arabia	Turkey
Armenia	China	Guam	Liberia	Nicaragua	Senegal	Turkmenistan
Azerbaijan	Colombia	Guatemala	Lithuania	Niger	Seychelles	Tuvalu
Bahamas	Comoros	Guinea	TFYR of Macedonia	Nigeria	Sierra Leone	Uganda
Bahrain	Congo	Guinea-Bissau	Madagascar	Niue	Singapore	Ukraine
Bangladesh	DR - Congo	Guyana	Malawi	N. Mariana Islands	Solomon Islands	Uruguay
Belarus	Cote d'Ivoire	Haiti	Malaysia	Pakistan	Somalia	Uzbekistan
Belize	Croatia	Honduras	Maldives	Palau	South Africa	Vanuatu
Benin	Djibouti	India	Mali	Panama	Spain	Venezuela
Bhutan	Dominican Republic	Indonesia	Mauritania	Papua New Guinea	Sri Lanka	Viet Nam
Bolivia	Ecuador	IR - Iran	Mauritius	Paraguay	Sudan	Wallis & Futuna Islands
Bosnia & Herzegovina	Egypt	Iraq	Mexico	Peru	Suriname	W. Bank & Gaza Strip
Botswana	El Salvador	Japan	Micronesia	Philippines	Swaziland	Yemen
Brazil	Equatorial Guinea	Kazakhstan	Moldova-Rep	Poland	Syrian Arab Republic	Zambia
Brunei Darussalam	Eritrea	Kenya	Mongolia	Portugal	Tajikistan	Zimbabwe
Bulgaria	Estonia	Kiribati	Montenegro	Qatar	Tanzania UR	
Burkina Faso	Ethiopia	DPR - Korea	Morocco	Romania	Thailand	
Burundi	Fiji	Republic of Korea	Mozambique	Russian Federation	Timor-Leste	

Source: World Health Organization Global Tuberculosis Control, WHO Report 2006, Countries with Tuberculosis incidence rates of > 20 cases per 100,000 population.

TB Screening & Risk Assessment Form

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NAME _____ STUDENT ID NUMBER _____

ADDRESS _____

DATE OF BIRTH _____ AGE _____ PHONE _____

TUBERCULOSIS (TB) RISK ASSESSMENT

(Required if "YES" was answered to any question on the TB Screening Questionnaire)

A. PATIENT SECTION

Recent close contact with someone with infectious TB disease	❑ Yes	❑ No
Foreign-born from (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America) *The significance of the travel exposure should be discussed with a health care provider and evaluated.	❑ Yes	❑ No
Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease	❑ Yes	❑ No
HIV/AIDS	❑ Yes	❑ No
Organ transplant recipient	❑ Yes	❑ No
Immunosuppressed (equivalent of > 15 mg/day of prednisone for >1 month or TNF-a antagonist)	❑ Yes	❑ No
History of illicit drug use	❑ Yes	❑ No
Resident, employee, or volunteer in a high-risk congregate setting (e.g. correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities).	❑ Yes	❑ No
Medical condition associated with increased risk of progressing to TB disease if infected [e.g., diabetes mellitus, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal for the given population)]	❑ Yes	❑ No

B. HEALTHCARE PROVIDER SECTION: Proceed with testing as per below if "yes" to any question in section A.

(*Please Note: All testing must be within 6 months prior to arriving on campus – Discuss the significance of exposure and evaluate the patient*)

1. Does the student have signs or symptoms of active tuberculosis disease?

❑ **Yes** Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing (TST), chest x-ray, and sputum evaluation as indicated.

❑ **No** Proceed to #2 or #3. Completion of either #2 or #3 is required for **all** students with any "yes" answers in section A.

2. Tuberculin Skin Test (TST) TST result must be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.

See guidelines listed on the Instructions for Completing the Required Immunization Forms. **If positive, proceed to step 4.

Date Given: ____/____/____ Date Read: ____/____/_____ Result: _____ mm induration **Interpretation: Positive____ Negative____

3. Interferon Gamma Release Assay (IGRA):

****If positive, proceed to step 4.** Check the specific method: QFT-G QFT-GIT Other_____

Date Obtained: ____/___/____ Result: Negative Positive Indeterminate

4. Chest X-Ray: Required if TST or IGRA is positive, or symptoms of active disease present. Attach a copy of the chest x-ray report to this document.

****If positive, proceed to step 5, if negative, proceed to step 6.**

Date of Chest X-ray: ____/____/_____ Result: Normal Abnormal

5. Sputum Evaluation: Required if TST or IGRA is positive and if chest X-ray is positive, or symptoms of active disease present. Attach a copy of the sputum report to this document. After completion go to step 6.

Date Performed: _____/____/_____ Result: Normal Abnormal

6. Diagnosis (check at least one)

****Required for all patients.**

_____ Active TB on Therapy
_____ Active TB Completed Therapy
_____ All tests Negative, (no disease)
_____ Other: _____
_____ Latent TB Infection on therapy
_____ Latent TB Infection declined or incomplete therapy
_____ Latent TB Infection completed therapy

REQUIRED SIGNATURE OF PHYSICIAN OR HEALTH FACILITY

NAME _____ (_____) _____ – _____ PHONE NUMBER

ADDRESS _____

SIGNATURE (PHYSICIAN OR HEALTHCARE FACILITY, PLEASE PRINT & SIGN BEFORE SUBMITTING) _____ / _____ / _____ DATE