EMORY UNIVERSITY | Student Health Services
Campus Life

1525 Clifton Road NE, Atlanta, Georgia 30322
Phone # 404-727-7552 Fax # 404-727-5349

Student Name: _____ Emory Student ID#: _____

Date of Birth (mm/dd/yyyy): _____ / _____ / _____ Date form completed: _____ / _____ / _____

IMMUNIZATION RECORD FOR SCHOOLS OF MEDICINE, ALLIED HEALTH AND NURSING STUDENTS

All incoming Emory students must meet the CDC and American College Health Association immunization guidelines, as outlined on the following pages. Be sure to have **BOTH PAGES OF THIS FORM SIGNED BY YOUR HEALTHCARE PROVIDER.** For immunizations that cannot be verified by your healthcare provider, you may attach a copy of your official, signed immunization records. If for any reason you or your healthcare provider feel that you cannot comply with any of Emory's immunization requirements (including medical contraindications to specific vaccinations), please attach a letter of explanation signed by both you and your healthcare provider. All vaccinations **MUST BE COMPLETED PRIOR TO MATRICULATION**, including all titers and labs. (Due dates to be determined by each degree program.) For more information about the required immunizations listed below, including indications and contraindications, please visit our web site at: **http://studenthealth.emory.edu/hs/new_students/immunization/index.html.**

Required Immunizations

1. Measles, Mumps and Rubella Requirement: *All students **born on or after January 1, 1957** must meet this requirement, either by having been vaccinated against the three diseases (either as the combined vaccine MMR or individual vaccinations against the 3 diseases) or showing laboratory evidence of immunity to all 3 diseases.*

EITHER:

Measles, Mumps, Rubella (MMR)

- ❑ Dose 1: At 12 month of age or older (provide month, day, year) **and** **Date:** ____ /_____/_____
- ❑ Dose 2: At 4-6 years of age or older (provide month, day, year) **Date:** ____ /_____/_____

OR ALL THREE OF THE FOLLOWING:

Measles (Rubeola, Red Measles or Ten-Day Measles) – Two doses of vaccine or a positive antibody titer

- ❑ Dose 1: At 12 months of age or older (provide month, day, year) **and** **Date:** ____ /_____/_____
- ❑ Dose 2: At 4-6 years of age or older (provide month, day, year), **or** **Date:** ____ /_____/_____
- ❑ Positive Antibody Titer (include copy of lab result) **Date:** ____ /_____/_____

Mumps – Two doses of vaccine or a positive antibody titer

- ❑ Dose 1: At 12 months of age or older (provide month, day, year) **and** **Date:** ____ /_____/_____
- ❑ Dose 2: At 4-6 years of age or older (provide month, day, year), **or** **Date:** ____ /_____/_____
- ❑ Positive Antibody Titer (include copy of lab result) **Date:** ____ /_____/_____

Rubella (German Measles or Three-Day Measles) – Two doses of vaccine or a positive antibody titer

- ❑ Dose 1: At 12 months of age or older (provide month, day, year) **and** **Date:** ____ /_____/_____
- ❑ Dose 2: At 4-6 years of age or older (provide month, day, year), **or** **Date:** ____ /_____/_____
- ❑ Positive Antibody Titer (include copy of lab result) **Date:** ____ /_____/_____

2. Tetanus-Diphtheria Requirement: *All students must have the basic primary series of 3 doses of Diphtheria-Tetanus (DTP or DTaP). In addition, all students must have had one Tdap booster in his/her lifetime. The 10-year booster following the Tdap may be a Td. Boosters are required every 10 years.*

- ❑ Tdap Vaccine **Date:** ____ /_____/_____
- ❑ Td Vaccine (if more than 10 years since last Tdap) **Date**: ____ /_____/_____

3. Hepatitis B Requirement: *All students must have a series of 3 Hepatitis B vaccinations (an initial dose, followed by a dose at 1-2 months and a dose at 4-6 months or later). A post-vaccine quantitative antibody titer is required before arrival for students in healthcare fields.*

- ❑ **Dose 1 Date:** ____ /_____/_____ **Dose 2 Date:** ____ /_____/_____ **Dose 3 Date:** ____ /_____/_____
- ❑ **Post-vaccine QUANTITATIVE antibody titer** (include copy of lab result): **Titer:** _____ **Titer Date:** ____ /_____/_____

4. Varicella (Chicken Pox) Requirement: *All students must have a positive Varicella antibody titer or 2 doses of the vaccine given at least 1 month apart.*

- ❑ Varicella Antibody Titer (include copy of lab result): **Positive titer date:** ____ /_____/_____ **or**
- ❑ Varicella Vaccination (provide month, day, year) **Dose 1 Date:** ____ /_____/_____ **and Dose 2 Date:** ____ /_____/_____

5. Tuberculosis Screening Requirement: *All Schools of Medicine, Allied Health and Nursing students must meet Emory's Tuberculosis Screening Requirement. Please refer to and complete the **"Tuberculosis Screening Requirement"** section on the next page for more information.*

Vaccinations Recommended but not Required

Please note that some programs may require certain vaccinations on the list below due to increased levels of risk/exposure.

6. Polio Immunization: *It is recommended that all students have a certified primary series of polio immunization (oral, inactivated or E-IPV).*

- ❑ Completed primary series of polio immunization. Type: Oral ___ Inactivated ___ **Completion Date:** ____ /_____/_____

7. Meningococcal (Meningitis ACWY) Vaccination:

- ❑ Meningococcal ACWY Vaccine (provide month, day, year) **Date:** ____ /_____/_____

8. Other Vaccinations, such as Hepatitis A, Pneumococcal, HPV *(include month, day, year)*: _____

_____

Verification of the above Student Immunization Record by healthcare provider:

_____ _____
Name/Title of Healthcare Provider Address

_____ _____/_____/_____ (_____) _____
Signature Date Phone

Student Name: _____ Date of Birth (mm/dd/yyyy): _____ / _____ / _____

TUBERCULOSIS SCREENING REQUIREMENT

Emory Schools of Medicine, Nursing and Allied Health require Tuberculosis (TB) screening (one PPD skin test, a chest x-ray, or an IGRA blood test) within 6 months of and at least two weeks prior to matriculation for all students. (If a PPD was done, a second PPD is also required and will be administered after matriculation.) Emory's guidelines are based upon the recommendations of the CDC and the American College Health Association.

For students from countries with a high prevalence of TB, an IGRA blood test is preferred. Because TB is so common globally, it is easier to list countries of *low* TB prevalence rather than high. Countries with *low* TB prevalence include:

Albania, American Samoa, Andorra, Antigua & Barbuda, Aruba, Australia, Austria, Bahamas, Bahrain, Barbados, Belgium, Bermuda, Bonaire/St. Eustatius/Saba, British Virgin Islands, Canada, Cayman Islands, Chile, Cook Islands, Costa Rica, Croatia, Cuba, Curacao, Cyprus, Czech Republic, Denmark, Dominica, Egypt, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Jordan, Lebanon, Luxembourg, Malta, Monaco, Monserrat, Netherlands, New Caledonia, New Zealand, Niue, Norway, Oman, Puerto Rico, St. Kitts & Nevis, St. Lucia, Samoa, San Marino, Saudi Arabia, Sint Maarten (Dutch part), Slovakia, Slovenia, Spain, Sweden, Switzerland, Syrian Arab Republic, (the former) Yugoslav Republic of Macedonia, Tokelau, Tonga, Turkey, Turks & Caicos Islands, United Arab Emirates, United Kingdom, United States, US Virgin Islands, Wallis & Futuna Islands, West Bank & Gaza Strip

Please select your degree program *(circle one):* **MD** **Nursing** **AA** **DPT** **Gen Counseling** **Medical Imaging** **PA**

1. **Tuberculin Skin Test (PPD/Mantoux skin test only - Tine NOT acceptable):** Date Placed: ____/____/____ Date Read: ____/____/____

   Result: _____mm (Record actual mm of induration, transverse diameter. If no induration, record as "0 mm.")

   Interpretation (based on mm of induration as well as risk factors): Positive _____ Negative _____

2. If PPD skin test is positive, one of the following must be provided:

   Chest x-ray (attach a copy of the CXR report) Normal _____ Abnormal _____ Date of Exam: ____/____/____

   OR

   IGRA blood test (attach a copy of the lab report for one of the following tests)

   ❒ Quantiferon Gold Positive _____ Negative _____ Date Drawn: ____/____/____

   ❒ T-spot Positive _____ Negative _____ Date Drawn: ____/____/____

3. **Treatment:** Have you been treated with anti-tubercular drugs? Yes _____ No _____

   If yes, type of treatment: _____ Length of treatment: _____

Verification of the above Tuberculosis Screening by healthcare provider:

_____ _____
Name/Title of Healthcare Provider Address

_____ _____/_____/_____ (_____) _____
Signature Date Phone

This paper form serves to provide verification of your immunization information. Before sending it to Emory, **please enter the information on this form electronically into *Your Patient Portal* at https://www.shspnc.emory.edu/login_directory.aspx.** Once the dates are entered, please submit a copy of this form. Please be certain that all sections and signatures have been completed (including the signature of your healthcare provider) and that you have met all applicable Emory University immunization requirements.

You may send this form to Emory in any of the following three ways:

- Scan and email to immunizations-shs@emory.edu. We advise you to use **your emory.edu email address** (e.g. lord.dooley@emory.edu). If you use a non-Emory email address (e.g. gmail, yahoo, etc.), your email and immunization documents will be outside the Emory firewall and we cannot guarantee their security. We prefer scanned **.pdf** documents for best visual quality and ease of upload into your Student Health electronic medical record.
- Fax to 404-727-5349
- Mail to:

Emory University Student Health Services
ATTN: Immunization Department
1525 Clifton Road NE, Atlanta, GA 30322

Revised June 8, 2017