Augusta University
Student Health Services
706-721-3448
immunizations@augusta.edu

Name: _____
Date of Birth: ____/_____/_____
Student ID: _____

The Graduate School – Biomedical Research

(research does not involve human subjects or patient contact)

CERTIFICATE OF IMMUNIZATION

Your health care provider must complete and sign this form. All information must be written in English.

This document must be submitted at least two (2) weeks prior to the start of the semester.

Please follow the directions at http://www.augusta.edu/shs/immunizations.php to submit your record.

REQUIRED IMMUNIZATIONS & TEST

Vaccine	Date: M/DD/YYYY	REQUIRED FOR & WHAT is needed
MMR (measles, mumps, rubella) ***OR*** **Measles** **Mumps** **Rubella**	#1 ___/___/___ **&** #2: ___/___/___ ***OR*** ___/___/___ & ___/___/___ ___/___/___ & ___/___/___ ___/___/___	**REQUIRED for students born after Jan. 1, 1957: vaccine or antibody titer**. **WHAT:** Two (2) doses of combined measles-mumps- rubella or "MMR" or separate vaccines for each measles, mumps, and rubella. The first dose of all vaccine types must be given at 12 months of age or later and the second dose of the MMR, measles, and mumps at least 28 days after the first dose ***OR*** - Measles & Mumps: 2 vaccine doses each **AND** Rubella: one vaccine dose ***OR*** - Attach copy of lab report of IgG blood antibody titer results for each virus: measles, mumps, and rubella as evidence of immunity.
Varicella	#1 __/__/__ & #2: __/__/__ OR IgG Titer: __/__/__ OR History of chicken pox: _/__/__	**REQUIRED** for all students born in the U.S. in 1980 or later and all foreign-born students. **WHAT**: 2 doses given at least 3 months apart if both doses are given before age 13 ***OR*** - 2 doses at least 4 weeks apart if first dose is given after 13th birthday ***OR*** - Documented history by physician of chicken pox or shingles ***OR*** - Attach copy of lab report of IgG antibody titer results as evidence of immunity.
Tetanus, Diphtheria, Pertussis (TDaP)	____/____/____ & If TDaP is > 10 years old, date of last Tetanus booster: ____/____/____	**REQUIRED** for all students. **WHAT:** One TDaP dose administered after 6/10/2005. If TDaP was administered more than 10 years ago, then a Td/TDaP dose is ALSO required.
Hepatitis B **[vaccine series & antibody titer & antigen]**	#1: ____/____/____ & #2: ____/____/____ & #3: ____/____/____ **AND** Quant. Hep B Surface Titer ___/___/____ **AND** Hep B Surface Antigen: ________	**REQUIRED:** All students: VACCINE SERIES, SURFACE ANTIBODY TITER, & SURFACE ANTIGEN **WHAT:** 3 dose of hepatitis B series (given at 0, 1-2, and 4-6 months) ***OR*** -3 dose combined hepatitis A and hepatitis B series (at 0, 1-2 and 6-12 months) **OR** -2 dose hepatitis B series of Recombivax (at 0 and 4-6 months) given at 11-15 years of age **AND** **- Attach copy of lab report of Hep B Surface Antibody titer results (QUANTITATIVE) AND Hepatitis B Surface Antigen.** If Hepatitis B Surface Antibody is negative, student must have one Hepatitis B booster vaccine and then repeat the Hepatitis B Surface Antibody titer 30 days later.
Tuberculosis (TB)	TB Screening Questionnaire found at: https://www.augusta.edu/shs/documents/undergradform.pdf	**REQUIRED**: All students must complete the "TB screening questionnaire" on pages 3-4 upon initial entry to AU. If your answer to any of the questions is "YES", then you need to have a TB screening test and have a health care provider complete the "Clinical Assessment" form on page 3.
Meningococcal (ACWY (MCV4)	#1 ___/___/___ **&** #2: ___/___/___ if initial dose more than 5 years ago	**REQUIRED:** All students living in on-campus housing or sorority/fraternity housing. **WHAT**: One dose if unvaccinated. If the initial dose was given more than 5 years ago, a booster is required. A student may sign a waiver and statement of understanding by going to: https://www.augusta.edu/shs/immunizationwaivers.php

STRONGLY RECOMMENDED IMMUNIZATIONS:

Vaccine	Date: MM/DD/YY	Date: MM/DD/YY	Date: MM/DD/YY	Notes:
COVID-19	/ /	/ /	/ /	Type:
Hepatitis A	/ /	/ /	Strongly recommended if travel outside of U.S.	
Meningococcal B	/ /	/ /	/ /	(Bexsero or Trumenba – circle)
HPV	/ /	/ /	/ /	Males and females through age 45 years
Influenza	/ /	-------	Annual - September to March; required for health professional students	

I attest that all of the above information is accurate and agree to the release of this information to Augusta University Student Health.

Student Signature: _____ **Date:** _____

REQUIRED SIGNATURE of licensed HEALTHCARE CLINICIAN*

Name: _____

Address: _____ Phone: _____

Signature: _____ Date: _____

* Healthcare Clinician can be a U.S. licensed physician, nurse practitioner, physician assistant or registered nurse.

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Submit this page only if you are claiming exemption from the USG Immunization requirements

STUDENT EXEMPTIONS

Select the appropriate box, sign, and date if you are claiming exemption of the immunization requirement for one of the following reasons:

☐ I affirm that the immunizations required by the University System of Georgia conflict with my religious beliefs. I understand I am subject to exclusion from all on-campus classes and activities in the event of an outbreak of disease for which immunization is required.

☐ I declare that I am enrolling ONLY in online classes and will not be attending any activities on any AU campus. If I subsequently register for even one in-person class, I must provide proof of immunizations at least two (2) weeks before registering.

I attest that all of the above information is accurate and agree to the release of this information to Augusta University Student Health.

Student Signature: _____ **Date:** _____

PERMANENT OR TEMPORARY MEDICAL EXEMPTIONS

Requires signature of licensed healthcare clinician:

☐ I affirm that this student is exempt from the above immunizations due to a permanent medical contraindication.

☐ I affirm that this student is temporarily exempt from the above immunizations until _____/____/_____.

REQUIRED SIGNATURE OF LICENSED HEALTHCARE CLINICIAN*
Name: _____
Address: _____ Phone: _____
Signature: _____ Date: _____

* Healthcare Clinician can be a U.S. licensed physician, nurse practitioner, physician assistant or registered nurse.

Any questions? Send email to: immunizations@augusta.edu

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AUGUSTA UNIVERSITY CERTIFICATE OF IMMUNIZATION

https://www.augusta.edu/shs/documents/undergradform.pdf

Please answer these questions –by checking the appropriate box ("Yes" or "No"):

1. Have you had close contact with persons known or suspected to have active TB? ☐ Yes ☐ No
2. Were you born in one of the countries listed below that have a high incidence of active TB? ☐ Yes ☐ No
   If yes, please **circle** the country below.

Afghanistan	Côte d'Ivoire	Japan	Nicaragua
Algeria	Croatia	Kazakhstan	Niger
Angola	Democratic People's Republic of Korea	Kenya	Nigeria
Argentina	Democratic Republic of the Congo	Kiribati	Pakistan
Armenia	Djibouti	Kuwait	Palau
Azerbaijan	Dominican Republic	Kyrgyzstan	Panama
Bahrain	Ecuador	Lao People's Democratic Republic	Papua New Guinea
Bangladesh	El Salvador	Latvia	Paraguay
Belarus	Equatorial Guinea	Lesotho	Peru
Belize	Eritrea	Liberia	Philippines
Benin	Estonia	Libyan Arab Jamahiriya	Poland
Bhutan	Ethiopia	Lithuania	Portugal
Bolivia (Plurinational State of)	Fiji	Madagascar	Qatar
Bosnia and Herzegovina	Gabon	Malawi	Republic of Korea
Botswana	Gambia	Malaysia	Republic of Moldova
Brazil	Georgia	Maldives	Romania
Brunei Darussalam	Ghana	Mali	Russian Federation
Bulgaria	Guam	Marshall Islands	Rwanda
Burkina Faso	Guatemala	Mauritania	Saint Vincent and the Grenadines
Burundi	Guinea	Mauritius	Sao Tome and Principe
Cambodia	Guinea-Bissau	Micronesia (Federated States of)	Senegal
Cameroon	Guyana	Mongolia	Seychelles
Cape Verde	Haiti	Morocco	Sierra Leone
Central African Republic	Honduras	Mozambique	Singapore
Chad	India	Myanmar	Solomon Islands
China	Indonesia	Namibia	Somalia
Colombia	Iraq	Nepal	South Africa
Comoros			Sri Lanka
Congo			

3. Have you had frequent or prolonged visits to one or more of the countries listed above? ☐ Yes ☐ No
   If yes, **check** the applicable countries.
4. Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, homeless shelters, long-term care facilities, etc.)? ☐ Yes ☐ No
5. Have you been a volunteer or healthcare worker who served clients/patients who were 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 or active TB disease: medical underserved, low-income, or abusing drugs or alcohol? ☐ Yes ☐ No
7. Have you ever had a positive TB skin test or IGRA blood test? ☐ Yes ☐ No
8. Have you had the BCG* vaccination? ☐ Yes ☐ No
   **The BCG vaccination is a vaccine for TB that is typically given in foreign countries with a higher incidence of TB. For more information regarding this vaccine, visit: https://www.cdc.gov/vaccines/vpd/tb/index.html .*

ATTESTATION STATEMENT:

I attest that the above information is accurate.

Student Signature: _____ Date: _____

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CLINICAL ASSESSMENT BY HEALTHCARE CLINICIANS

1. Please review and verify the TB Questionnaire responses. If any are answered "YES", they are candidates for either tuberculin skin test or Interferon Gamma Release Assay (IGRA) unless a previous positive test has been documented.
2. History of positive TB skin test or IGRA blood test? ☐ Yes (document below) ☐ No
   History of BCG vaccination? ☐ Yes (consider IGRA if possible) ☐ No
3. TB Symptoms Check: Does the student have signs or symptoms of active pulmonary TB disease? ☐ Yes ☐ No
4. Proceed with further tests to exclude active TB, including chest X-ray as medically indicated.
5. Diagnostic/screening tests:
   - Tuberculin Skin Test (TST):
     - Date Given: _____ Date Read: _____
     - Skin test result = _____mm induration; interpretation* = ☐ positive ☐ negative
   - Interferon Gamma Release Assay (IGRA)
     - Date obtained: ____/____/____ Specify method: ☐ QFT-GIT ☐ T-spot ☐ other
     - Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ borderline (T-spot only)
   - Chest X-ray (required if TST or IGRA is positive):
     - Date of chest X-ray: _____/_____/____ Result: ☐ normal ☐ abnormal (acute pulmonary TB)

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*TST Interpretation guidelines:

≥ 5 mm is positive:
- recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunocompromised persons

≥ 10mm is positive:
- recent arrival to the U.S. (<5 years) from high prevalence areas
- injection drug users
- Mycobacteriology lab personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease, including immunosuppressive disorders, silicosis, diabetes mellitus, chronic renal failure, and certain types of cancer (e.g., leukemias and lymphomas, cancers of head/neck/lung), gastrectomy or jejunoileal bypass, weight loss > 10% below ideal body weight

≥ 15 mm is positive:
- persons with no known risk factors for TB

REQUIRED SIGNATURE of licensed HEALTHCARE CLINICIAN*

Name: _____ Address: _____ Phone: _____

Signature: _____ Date: _____

* Healthcare Clinician can be a U.S. licensed physician, nurse practitioner, physician assistant or registered nurse.