**Augusta University**
**Student Health Services**
**706-721-3448**

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

## AUGUSTA UNIVERSITY 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 semester.***

## REQUIRED IMMUNIZATIONS – HEALTH PROFESSIONAL STUDENTS

| Vaccine | Date: M/DD/YYYY | REQUIRED FOR & WHAT is needed |
|---|---|---|
| **MMR (Measles, mumps, rubella) [vaccine series *OR* antibody titer for each]** | #1 ___/___/___<br>#2: ___/___/___ ***OR***<br><br>IgG Titer: ___/___/____ | **REQUIRED** for all students: **VACCINE SERIES *OR* IgG ANTIBODY TITER**<br>**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 at least 28 days (about 4 weeks) after the first dose. ***OR***<br>**- Attach copy of lab report of IgG blood antibody titer results for each virus: measles, mumps and rubella, documenting immunity for each.** |
| **Varicella**<br><br>**[vaccine series *OR* antibody titer]** | #1 __/___/___<br>#2: __/___/___ ***OR***<br><br>IgG Titer: ___/___/____ | **REQUIRED** for all students: **VACCINE SERIES *OR* IgG ANTIBODY TITER**<br>**WHAT**: 2 doses given at least 3 months apart if both doses are given before age 13 ***OR***<br>- 2 doses at least 4 weeks apart if first dose is given after 13th birthday ***OR***<br>- **Attach copy of lab report of IgG antibody titer results as evidence of immunity.** |
| **Tetanus, Diphtheria, Pertussis (TDaP)** | _____/____/____<br><br>____/____/____ *(IF NEEDED)* | **REQUIRED** for all students.<br>**WHAT:** One Tdap dose administered after 6/10/2005.<br>If TDaP was administered more than 10 years ago, then a Tdap or Td booster dose is **ALSO** required. |
| **Hepatitis B**<br><br>**[vaccine series & antibody titer *&* antigen]** | #1: ____/____/____<br>#2: ____/____/____<br>#3: ____/____/____ ***AND***<br>Quant.Hep B Surface Antibody titer: ___/___/___ ***AND***<br>Hepatitis B Surface Antigen: ___/___/___ | **REQUIRED** for all students: **VACCINE SERIES, SURFACE ANTIBODY TITER, & SURFACE ANTIGEN**<br>**WHAT:** 3 dose of hepatitis B series (given at 0, 1-2, and 4-6 months) ***OR***<br>- 3 dose combined hepatitis A and hepatitis B series (at 0, 1-2 and 6-12 months) ***OR***<br>- 2 dose hepatitis B series of Recombivax (at 0 and 4-6 months) given at 11-15 years of age ***AND***<br>- **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 a one Hepatitis B booster vaccine and then repeat the Hepatitis B Surface Antibody titer 30 days later. |
| **Influenza** | _____/_____/_____ | **REQUIRED** annually for all students: September through April. |
| **Tuberculosis (TB)** | Must be completed ***within* 3 months** of the start of class | **REQUIRED:** for all students: **PPD Skin Test or QuantiFERON Gold Blood Test**<br>- **Attach copy of lab report of QuantiFERON Gold Blood Test**. If positive, the student must submit a chest x-ray |
| **Meningococcal (ACWY) (MCV4)** | #1 ___/___/___<br>#2: ___/___/___ if initial dose more than 5 years ago | **REQUIRED:** All students living in on-campus housing or sorority/fraternity housing.<br>**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:<br>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 type given) |
| **HPV** | / / | / / | / / | Males and females through age 45 years |

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

**Student Signature:** _____ **Date:** _____

**REQUIRED SIGNATURE OF licensed HEALTHCARE CLINICIAN** (physician, nurse practitioner, physician assistant, or RN)

Name: _____

Address: _____ Phone: _____

Signature: _____ Date: _____

## *ADDITIONAL REQUIREMENTS*

**TUBERCULOSIS TESTING:** *must be done within three months prior to start of classes.*
Please submit documentation of the following:

PPD Skin Test ***OR*** QuantiFERON Gold blood test – *Please attach a copy of the PPD Reading **OR** complete QuantiFERON Gold lab results to include your name, date of birth, test results and date of specimen collection. This is an annual requirement.*

**REQUIRED LAB ANTIBODY TITERS** - *Please attach a copy of the complete lab results to include your name, date of birth, test results and date of specimen collection.*

Hepatitis B Surface Antibody (quantitative) ***AND*** Hepatitis B Surface Antigen.

**If the antibody is negative (i.e., not immune), you will be required to have one Hepatitis B vaccine, followed by the repeat Antibody 30 days later.**

***Please be advised that some clinical/rotation sites may require additional testing.***

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

- *Please follow the directions at http://www.augusta.edu/shs/immunizations.php*

- **Visit augusta.medicatconnect.com to submit your immunization records and associated documents.**

**THANK YOU!**