



# 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

# Certificate of Immunization

NAME: \_\_\_\_\_  
Last First

Virginia Commonwealth University

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	
<b>Diphtheria, tetanus, pertussis (DPT)</b>	has received _____ doses, last dose given _____ M D Y	
<b>Tetanus, diphtheria, pertussis (Tdap) Required</b> after age 11 and within 10 years	_____ M D Y	<b>OR Tetanus, diphtheria (Td)</b> within 10 years _____ M D Y
<b>Polio IPV or OPV</b>	has received _____ doses, last dose given _____ M D Y	<b>OR</b> Serological confirmation of immunity. <b>Attach copy of lab result.</b>
<b>Hepatitis A</b>	① _____ ② _____	
<b>Hepatitis B or combined Hep A/B</b>	① _____ M D Y ② _____ M D Y ③ _____ M D Y	<b>OR</b> Serological confirmation of immunity. <b>Attach copy of lab result.</b> <b>OR</b> Waiver signed.
<b>Measles, mumps, rubella (MMR)</b> after first birthday and 4/71.	① _____ M D Y ② _____ M D Y	<b>OR</b> serological confirmation of immunity to measles, mumps and rubella. <b>Attach copy of lab result.</b>
<b>Human Papillomavirus</b>	① _____ M D Y ② _____ M D Y ③ _____ M D Y	<input type="checkbox"/> Gardasil <input type="checkbox"/> Other
<b>Meningococcal vaccine</b>	① _____ M D Y ② _____ M D Y	<b>OR</b> Waiver signed. <input type="checkbox"/> MCV4 given <input type="checkbox"/> MPSV4 given
<b>Tuberculosis Screening</b> (In the United States within the last year. See the back of this form.)	<b>1. Not at high-risk for TB exposure</b> No skin test placed.  <b>2. History of prior positive TB skin test</b> Complete attached Tuberculosis Assessment Form and <b>attach copy of chest x-ray report.</b>  <b>3. At high risk for TB exposure or entering the health professions</b> TB skin test placed Date placed _____ Date read _____ Interpretation _____pos_____neg _____mm induration (if none, write 0) <b>If positive: complete attached Tuberculosis Assessment Form</b>	
<b>Varicella (Chicken Pox)</b> Required for MCV Campus students	Date of Disease _____ M D Y	<b>AND</b> Serological confirmation of immunity. <b>Attach copy of lab result.</b> <b>OR vaccines</b> ① _____ M D Y ② _____ M D Y
<b>= Required</b>		

### 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

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 \_\_\_\_\_

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.

# Immunizations

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 required for all medical campus students.

Ⓡ = 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.

## TUBERCULOSIS ASSESSMENT

For students with POSITIVE Tuberculin skin tests

Name \_\_\_\_\_

Date of birth \_\_\_\_\_ Student ID# \_\_\_\_\_

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. 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.

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I am aware that the six symptoms listed above are possible signs/symptoms of active tuberculosis disease that I should promptly report to my healthcare provider.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

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

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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 strokes.

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. Meningitidis is not recommended.

The vaccine is available through your private health care provider, most local health departments and University Student Health Services.