Certificate of Immunization

LONGWOOD UNIVERSITY

Fill out completely and return to:

Longwood University
Student Health & Wellness Center
201 High Street
Farmville, VA 23909

Part I -- To be completed by student

Name: ____
Last First Middle

Date of Birth: ______________________________________

❑ **Religious Exemption** -- Enclose certificate notorized from your state health department.

MEDICAL EXEMPTION:

___ DPT ___ Td ___ OPV ___ Measles ___ Rubella ___ Mumps

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 ___/___/___.

❑ **Nursing Major** ❑ **Athletic Training Major**

Permission for treatment - signature of parent/guardian (if student is under 18 at time of matriculation)
The law requires that parental permission be obtained in order to provide medical care to minors.

I hereby authorize the clinicians of Longwood University Student Health and Wellness Center to examine, interview, test and if necessary, treat as they may deem advisable and to disclose such information to other responsible University officials as necessary.

Signature: ______________________ Date: __________

______________________ __________
Longwood Reviewer Date

Part II -- 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	VACCINATION DATES
	Polio	completed primary series, __ / __ / __ (M D Y)
	Diphtheria, tetanus, pertussis	completed primary series, __ / __ / __ (M D Y)
R	**Adult Tetanus diphtheria, (Td)** **Required** within 10 years	__ / __ / __ (M D Y)
R	**Measles, mumps, rubella** (MMR), two doses given after first birthday. **Nursing - MMR Titers Required (attach copy of lab result)**	1) __ / __ / __ (M D Y) 2) __ / __ / __ (M D Y) **OR** Serological confirmation of immunity 3) __ / __ / __ (M D Y) **OR** ❑ Born before 1957
	Varicella (Chicken Pox) **Nursing - Titer Required (attach copy of lab result)**	1) __ / __ / __ (M D Y) 2) __ / __ / __ (M D Y) **OR** Date of Disease __ / __ / __ (M D Y)
R	**Hepatitis B** **Nursing and Athletic Training - Required Series**	1) __ / __ / __ (M D Y) 2) __ / __ / __ (M D Y) 3) __ / __ / __ (M D Y) **OR** I have read the information on the website (www.longwod.edu/health/immunizations.htm) and choose not to be vaccinated ______ SIGNATURE OF STUDENT OR GUARDIAN IF WAIVED
R	**Meningococcal vaccine** **Nursing - Required**	__ / __ / __ (M D Y) **OR** I have read the information on the website (www.longwood.edu/health/immunizations.htm) and choose not to be vaccinated. ______ SIGNATURE OF STUDENT OR GUARDIAN IF WAIVED

R **TUBERCULOSIS SCREENING**

High risk students include those students who have arrived ≤ 5 years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamacia, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high risk students include those with: HIV infection, who inject drugs, who have resided, volunteered, or worked in high risk congregate settings e.g. prisons, nursing homes, hospitals, homeless shelters, residential facilities for AIDS patients; those who have clinical conditions e.g. diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndrome, prolonged corticosteroid therapy, or other immunosuppressive disorders.

Please circle appropriate number.

1.
Not at high-risk for TB exposure
No skin test placed.

Nursing - PPD and/or negative chest xray required annually

2.
At high risk for TB exposure or entering the health professions
TB skin test placed
Date placed ______________
Date read ______________
______ mm induration (if none, write 0)
interpretation ____ pos ____ neg

IF POSITIVE, MUST COMPLETE CATEGORY 3

3.
History of prior positive TB skin test
Date pos ______________
Date of negative chest Xray ______________
Dates TB prevention medications taken ______________
No TB prevention medications taken ______________

R =Required

____
Signature or Stamp of Health Care Provider Date Phone