



IMMUNIZATION RECORD

PART I – TO BE COMPLETED BY STUDENT

Name _____
Last
First
Middle

Address _____
Street
City
State
Zip

Date of Entry ___/___/___ Date of Birth ___/___/___ School ID# _____

Status: Full-time _____ Part-time _____ Graduate _____ Undergraduate _____

___ **Immunization Religious Exemption**– enclose notarized certificate from your state health department

*****PERMISSION TO TREAT***** (If you are under 18, your parent/guardian must sign below in order for you to be seen at the SHWC.)

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

Signature _____ Date _____

PART II – TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER (all information must be in English)

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 ___/___/___

REQUIRED IMMUNIZATIONS (Record as Month/Day/Year)

A. MMR (MEASLES, MUMPS, RUBELLA) (Two doses **required** at least 28 days apart for students born after 1956)

Dose 1 given at age 12 months or later #1 ___/___/___

Dose 2 given at least 28 days after first dose. #2 ___/___/___

***Nursing – MMR Titers Required (attach copy of lab results)**

B. POLIO (Primary series, doses at least 28 days apart with last dose after age 4 years. Three dose primary series is acceptable.)

OPV alone (oral Sabin three doses): #1 ___/___/___ #2 ___/___/___ #3 ___/___/___

IPV/OPV sequential: IPV #1 ___/___/___ IPV #2 ___/___/___ OPV #3 ___/___/___ OPV #4 ___/___/___

IPV alone (injected Salk four doses): #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___

C. TETANUS, DIPHTHERIA, PERTUSSIS

Primary series completed? Yes ___ No ___

Date of last dose in series: ___/___/___

Date of most recent booster dose: ___/___/___ (must be less than 10 years ago)

Type of booster: Td ___ Tdap ___ (Tdap booster recommended for ages 11-64 unless contraindicated)

Name: _____
Last First Middle

DOB: ____/____/____
M D Y

D. HEPATITIS B (Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or a positive hepatitis B surface antibody meets the requirement.) **Nursing and Athletic Training Students CANNOT Waive**

1. Immunization (hepatitis B)

a. Dose #1 ____/____/____ b. Dose #2 ____/____/____ c. Dose #3 ____/____/____
Adult formulation ____ Child formulation ____ Adult formulation ____ Child formulation ____ Adult formulation ____ Child formulation ____

2. Immunization (combined hepatitis A and B vaccine)

a. Dose #1 ____/____/____ b. Dose #2 ____/____/____ c. Dose #3 ____/____/____

3. Hepatitis B surface antibody date ____/____/____ Result: Reactive ____ Non-reactive ____

OR: I have read the information on the website (www.longwood.edu/health) and choose not to be vaccinated

Signature of student or guardian if waived

E. MENINGOCOCCAL QUADRIVALENT One or 2 doses for all college students with last dose on or after 16th birthday– revaccinate every 5 years if increased risk continues. **Nursing Students CANNOT Waive**

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).

a. Dose #1 ____/____/____ b. Dose #2 ____/____/____

2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available).

Date ____/____/____

OR: I have read the information on the website (www.longwood.edu/health) and choose not to be vaccinated

Signature of student or guardian if waived

RECOMMENDED IMMUNIZATION (Record as Month/Day/Year)

F. VARICELLA (Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement.)

History of Disease: Yes ____ No ____ or Birth in U.S. before 1980 Yes ____ No ____

Varicella antibody ____/____/____ Result: Reactive ____ Non-reactive ____

***Nursing – Titer required (attach copy of lab results)**

Immunization

a. Dose #1 ____/____/____

b. Dose #2 ____/____/____ (given at least 12 wks. after first dose ages 1-12 yrs. and at least 4 weeks after first dose if age 13 yrs. or older)

G. HUMAN PAPILLOMAVIRUS VACCINE (HPV2 or HPV4) (3 doses of vaccine for all students 11-26 yrs. of age at 0, 1/2, and 6m intervals)

Immunization (indicate which preparation) Quadrivalent (HPV4) ____ or Bivalent (HPV2) ____

a. Dose #1 ____/____/____ b. Dose #2 ____/____/____ c. Dose #3 ____/____/____

H. INFLUENZA

Date of last dose: ____/____/____ Trivalent inactivated influenza vaccine (TIV) ____ Live attenuated influenza vaccine (LAIV) ____

I. HEPATITIS A

1. Immunization (hepatitis A)

a. Dose #1 ____/____/____ b. Dose #2 ____/____/____

2. Immunization (Combined hepatitis A and B vaccine)

a. Dose #1 ____/____/____ b. Dose #2 ____/____/____ c. Dose #3 ____/____/____

J. PNEUMOCOCCAL POLYSACCHARIDE VACCINE (One dose for members of high-risk group)

Date ____/____/____

Name: _____
Last First Middle

DOB: ____/____/____
M D Y

PART III – TO BE COMPLETED BY STUDENT AND HEALTH CARE PROVIDER

Tuberculosis (TB) Screening/Risk Assessment for All Entering Students

Student, please answer the following questions:

1. Have you ever had a positive TB skin test? Yes No
2. Have you ever had close contact with anyone who was sick with TB? Yes No
3. Were you born in a country NOT listed below and arrived in the U.S. within the past 5 years? Yes No
If YES what country? _____
4. Have you ever traveled* to/in one or more country NOT listed below? Yes No
If YES what country(ies)? _____
5. Have you ever been vaccinated with BCG? Yes No
6. Are you an Athletic Training or Nursing major? Yes (PPD/IGRA and/or negative CXR required annually) No

Albania, Andorra, Antigua and Barbuda, Australia, Austria, Bahamas, Barbados, Belgium, British Virgin Islands, Canada, Chile, Costa Rica, Cuba, Cyprus, Czech Republic, Denmark, Dominica, Egypt, Fiji, Finland, France, Germany, Greece, Grenada, Hungary, Iceland, Iran (Islamic Republic of), Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Luxembourg, Malta, Mexico, Nauru, Netherlands, New Zealand, Norway, Oman, Puerto Rico, Saint Kitts and Nevis, Saint Lucia, Samoa, Saudi Arabia, Slovakia, Slovenia, Spain, Sweden, Switzerland, United Arab Emirates, United Kingdom, United States of America, West Bank and Gaza Strip

Health Care Provider: Please review above and complete remainder of tuberculosis risk assessment (to be completed within six months prior to the start of classes). Individuals with any of the following are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

Risk Factor

1. Recent close contact with someone with infectious TB disease Yes No
2. Foreign-born from (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America) Yes No
3. Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease Yes No
4. HIV/AIDS Yes No
5. Organ transplant recipient Yes No
6. Immunosuppressed (equivalent of > 15 mg/day of prednisone for >1 month or TNF- α antagonist) Yes No
7. History of high risk illicit drug use Yes No
8. Resident, employee, student or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities) Yes No
9. Medical condition associated with increased risk of progressing to TB disease if infected [e.g., diabetes mellitus, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal for the given population)] Yes No

* The significance of the travel exposure should be discussed with a health care provider and evaluated.

1. Does the student have signs or symptoms of active tuberculosis disease? Yes No
If YES, proceed with additional evaluation to exclude active tuberculosis disease including TST/IGRA, chest x-ray, and sputum evaluation as indicated. If NO and any previous answers yes proceed to 2 or 3.

2. Tuberculin Skin Test (TST) (TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ____/____/____ Date Read: ____/____/____

Name: _____
Last First Middle

DOB: ____/____/____
M D Y

Result: _____ mm of induration **Interpretation: positive____ negative____

(If 2 step test needed complete 2nd test 1-3 weeks from first test)

Date Given: ____/____/____ Date Read: ____/____/____

Result: _____ mm of induration **Interpretation: positive____ negative____

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/____/____ (specify method) QFT-G QFT-GIT T-Spot other____

Result: negative____ positive____ indeterminate____ borderline____ (T-Spot only)

Date Obtained: ____/____/____ (specify method) QFT-G QFT-GIT T-Spot other____

Result: negative____ positive____ indeterminate____ borderline____ (T-Spot only)

4. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: ____/____/____ Result: normal____ abnormal____

5. TB prevention medication taken: Yes No If yes, dates taken: ____/____/____ - ____/____/____

****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
- Immunosuppressed persons: taking > 15 mg/d of prednisone for >1 month; taking a TNF- α antagonist
- Persons with HIV/AIDS

- Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes

*The significance of the travel exposure should be discussed with a health care provider and evaluated.

>10 mm is positive:

- Persons born in a high prevalence country or who resided in one for a significant* amount of time
- History of illicit drug use
- Mycobacteriology laboratory personnel
- History of resident, worker, student or volunteer in high-risk congregate settings

>15 mm is positive:

- Persons with no known risk factors for TB disease.

ADDITIONAL COMMENTS

HEALTH CARE PROVIDER

SIGNATURE _____

ADDRESS _____

DATE _____

PHONE _____

Longwood Reviewer

Date