Immunization Form

Date ____ | ____ | ____

Student Health Services

LOCATION 200 Georgia Ave. • **ADDRESS** 1500 N. Patterson St. • Valdosta, GA 31698–0175
PHONE 229.333.5886 • **FAX** 229.249.2791 • **WEB** www.valdosta.edu/health

ALL FORMS MUST BE COMPLETED IN ENGLISH

You can submit this form by uploading it to the Health Center's Online Portal, located at **www.valdosta.edu/health** or you may send the form as a PDF to **immunizations@valdosta.edu**. Questions can be emailed to **immunizations@valdosta.edu** or you may call us at **229.219.3203**.

NAME ________________ VSU STUDENT ID NUMBER ________________

ADDRESS ________________

DATE OF BIRTH ________ AGE ________ PHONE ________

CERTIFICATE OF IMMUNIZATIONS (REQUIRED)

REQUIRED IMMUNIZATIONS	REQUIREMENT		REQUIRED FOR:
MMR (Measles, Mumps, Rubella) combined shot	• 2 Doses	#1 ____/____/____ #2 ____/____/____	• **Students born in 1957 or later and all foreign born students, regardless of year born**
OR		**OR**	
• Measles (Rubella)	• 2 Doses • **or Titer**	#1 ____/____/____ #2 ____/____/____ ____/____/____	• **Students born in 1957 or later**
and		**and**	
• Mumps	• 2 Doses • **or Titer**	#1 ____/____/____ #2 ____/____/____ ____/____/____	• **Students born in 1957 or later**
and		**and**	
• Rubella (German Measles)	• 1 Dose • **or Titer**	#1 ____/____/____ ____/____/____	• **Students born in 1957 or later** • **Attach titer results with lab values**
Varicella (Chicken Pox)	• 2 Doses • **or** History of chicken pox **or** shingles • **or Titer**	#1 ____/____/____ #2 ____/____/____ ____/____/____ ____/____/____	• **All *U.S. born* students born in 1980 or later and *all foreign* born students, regardless of year born** • **Attach titer results with lab values**
Tetanus-Diphtheria-Pertussis (Whooping Cough) or Td booster	• Tdap • Td Booster	____/____/____ ____/____/____	• **All students must have one dose of Tdap or One Td booster if it has been ≥10 years after receiving Tdap**
Hepatitis B	• 3 Dose series • **or Titer**	#1 ____/____/____ #2 ____/____/____ #3 ____/____/____ ____/____/____	• **All students 18 years of age and <u>under</u> at matriculation**
Tuberculosis screening	• **All students**, must complete TB screening questionnaire		• **If the answer to any of the TB screening questions is "YES", must complete TB Risk Assessment, Part II – to be completed by a physician**

RECOMMENDED IMMUNIZATIONS

Hepatitis A	2 Doses	#1 ____/____/____	#2 ____/____/____	
Human Papillomavirus (HPV-Gardasil)	3 Doses	#1 ____/____/____	#2 ____/____/____	#3 ____/____/____
Meningitis (A,C,Y,W)		#1 ____/____/____	#2 ____/____/____	
Meningitis B	2 or 3 Doses	#1 ____/____/____	#2 ____/____/____	#3 ____/____/____
Other vaccines:	____________	____/____/____	____________	____/____/____

REQUEST FOR EXEMPTION

PERMANENT OR TEMPORARY IMMUNIZATION EXEMPTION (check appropriate area)

- ❑ This student is exempt from above immunizations on the ground of permanent medical contraindication.
- ❑ This student is temporarily exempt from the above immunization until ______/______/______ .

Religious or Distance Learning Exemptions — In the event of an outbreak, exempted persons may be subject to exclusion from school and to quarantine, until proof of vaccination(s) is provided. If you begin taking courses **"on campus"**, you will no longer be "exempt" and will be required to submit your immunization form.

If religious exemption is required, please sign here — ________________ STUDENT SIGNATURE

If you declare that you are enrolling in **ONLY** courses offered by distance learning, please sign here — ________________ STUDENT SIGNATURE

REQUIRED SIGNATURE OF PHYSICIAN OR HEALTH FACILITY

NAME ________________ (______) ______ – ________ PHONE NUMBER

ADDRESS ________________

SIGNATURE (PHYSICIAN OR HEALTHCARE FACILITY, PLEASE PRINT & SIGN BEFORE SUBMITTING) ________________ ______ / ______ / ______ DATE

Medical Entrance Form

Student Health Services

LOCATION 200 Georgia Ave. • **ADDRESS** 1500 N. Patterson St. • Valdosta, GA 31698–0175
PHONE 229.333.5886 • **FAX** 229.249.2791 • **WEB** www.valdosta.edu/health

Date
_____|_____|_____

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SEMESTER BEGINNING | DATE | VSU STUDENT ID NUMBER | DATE OF BIRTH | AGE AT TIME OF APPLICATION

NAME (LAST, FIRST, MIDDLE)

ADDRESS | CITY | STATE | COUNTRY

ZIP CODE | CELL PHONE (______) ______ – ________ | EMAIL

***This information will remain confidential and will be utilized by Student Health Services personnel only.**

1. ALLERGIES (List all medication, food, insect or other known allergies below)

____

____

Do you receive allergy shots? ❑ YES ❑ NO If yes, please have your allergy records faxed to 229.249.2791 .

2. HOSPITALIZATION (List all prior hospitalizations, surgeries, and procedures)

____

____

3. MEDICATION (List all medications including doses that you are currently taking)

____

____

4. MEDICAL HISTORY

Are you now or have you been under the care of a physician for an ongoing illness/medical condition? ❑ YES ❑ NO
Do you have a chronic (long-lasting or persistent) medical condition that requires treatment or medication? ❑ YES ❑ NO
If yes, please have your physician fax a summary of your treatment to **229.249.2791** that includes the following:

- Condition being treated
- Type of medicine
- Physician's name, address and phone number

Please check all that apply

- ❑ Emphysema
- ❑ Tuberculosis
- ❑ Pneumonia
- ❑ Bronchitis
- ❑ Allergies
- ❑ Diabetes
- ❑ Cirrhosis
- ❑ Fractures
- ❑ Arthritis
- ❑ Thyroid Trouble
- ❑ Cardiovascular Disease
- ❑ Anemia
- ❑ Migraines
- ❑ Heart Disease
- ❑ Prostate Trouble
- ❑ Elevated Cholesterol
- ❑ Stroke
- ❑ Hepatitis A
- ❑ Osteoporosis
- ❑ Ulcerative Colitis
- ❑ Anxiety or Panic Disorder
- ❑ Asthma
- ❑ Hepatitis B
- ❑ Crohn's Disease
- ❑ Sickle Cell Disease
- ❑ Irritable Bowel Syndrome
- ❑ Ulcers
- ❑ Hepatitis C
- ❑ Cystic Fibrosis
- ❑ Gallbladder Disease
- ❑ Cancer
- ❑ Depression
- ❑ Venous Thrombosis
- ❑ High Blood Pressure
- ❑ Post-traumatic Stress Disorder
- ❑ Sexually Transmitted Infections
- ❑ Frequent Urinary Tract Infections
- ❑ Bleeding Disorder or Other Blood Disorders
- ❑ Alcohol/Substance Abuse Problem
- ❑ Other: ____________________
  ____

Do you have a living will, advanced directive, durable power of attorney for healthcare or physician order for life sustaining treatment?
(If yes, submit with your medical records forms to Student Health Services.) ❑ YES ❑ NO

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Date
_____|_____|_____

5. AUTHORIZATION TO TREAT (If you are 18 years of age or OVER)

- The General Consent for treatment gives permission to personnel of Valdosta State University Health Services to perform a medical evaluation including obtaining a history, doing a physical exam, performing a diagnostic workup and providing treatment, including minimally invasive procedures such as venipuncture to draw blood, x-rays, and IV catheter insertion to administer medications or IV fluids.
- The patient has the right to refuse any treatment.
- A record of General Consent for Treatment will be stored in the patient's medical record.
- Duration of General Consent for Treatment has continuing force and effect until the patient revokes the consent.

I hereby authorize the physicians, physician assistants, and nurse practitioners of Valdosta State University Health Services and their agents or consultants, including those at area hospitals and/or Georgia Department of Public Health, to perform diagnostic and treatment procedures which in their judgment may be necessary while I am at Valdosta State University. I understand I am responsible for charges incurred.

______________________________ ______ / ______ / ______
PATIENT SIGNATURE DATE

6. AUTHORIZATION TO TREAT (If you are UNDER 18 years of age)

I hereby authorize the physicians, physician assistants, and nurse practitioners of Valdosta State University Health Services, and their agents or consultants, including those at area hospitals and/or Georgia Department of Public Health, to perform diagnostic and treatment procedures which in their judgment may be necessary while he/she attends Valdosta State University. I waive all claim to prior notification. I understand that every reasonable effort will be made to notify me in the event of a major illness or injury, or if the Valdosta State University Health Services physician feels it is necessary. I understand I am responsible for charges incurred.

______________________________ ______ / ______ / ______
PATIENT SIGNATURE DATE

______________________________ ______ / ______ / ______
SIGNATURE OF PARENT/GUARDIAN DATE

EMERGENCY CONTACT INFORMATION

______________________________ ______________
NAME RELATIONSHIP

____
ADDRESS

____
CITY STATE COUNTRY ZIP CODE

(______) ______ – ______ (______) ______ – ______ ______________
DAYTIME PHONE EVENING PHONE EMAIL

______________________________ ______________
NAME RELATIONSHIP

____
ADDRESS

____
CITY STATE COUNTRY ZIP CODE

(______) ______ – ______ (______) ______ – ______ ______________
DAYTIME PHONE EVENING PHONE EMAIL

PLEASE NOTE: RETURN THESE FORMS TO STUDENT HEALTH SERVICES ***PRIOR*** TO YOUR ORIENTATION DATE.

Students should keep a copy of these forms for their personal records.

______________________________ ______________
NAME VSU STUDENT ID NUMBER

TB Screening & Risk Assessment Form

Date

____ | ____ | ____

Page 1

Student Health Services

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NAME ______________________ STUDENT ID NUMBER ______________________

ADDRESS ______________________

DATE OF BIRTH __________ AGE __________ PHONE __________

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE (REQUIRED)

Complete this form and return to VSU Student Health Services prior to your orientation date. All forms must be completed prior to arriving on campus.

1. Have you ever had close contact with persons known or suspected to have active TB disease? ❑ Yes ❑ No
2. Were you born in one of the countries listed below that have a high incidence of active TB disease? (If YES, please CIRCLE the country, below) ❑ Yes ❑ No
3. Have you had frequent or prolonged visits to one or more countries listed below with a high prevalence of TB disease? (If YES, CHECK the countries, below) ❑ Yes ❑ No
4. Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ❑ Yes ❑ No
5. Have you been a volunteer or health-care worker who served clients who are 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 *M. tuberculosis* infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol? ❑ Yes ❑ No

If the answer is YES to any of the above screening questions, you must complete the TB Risk Assessment.

If you answered yes to any of the above questions, Valdosta State University requires that students complete a tuberculosis risk assessment by a physician or healthcare facility. This TB Risk Assessment must be completed no later than 30 days following the first day of the initial semester at Valdosta State University. The TB Risk Assessment may be completed at Student Health Services at Valdosta State University following the first day of classes during the initial enrolled semester.

****If the answer is NO to all of the above questions, you may sign and no further assessment is required.****

You may also mail this signed form to the VSU Student Health Services, 200 Georgia Ave., Valdosta, GA 31698 or fax to 229.249.2791.

SIGNATURE OF STUDENT ______________________ DATE ______ / ______ / ______

OR Signature of parent/guardian if student is UNDER 18 years old

**List of countries:*

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bahamas
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia & Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Republic
Chad
China
Colombia
Comoros
Congo
DR - Congo
Cote d'Ivoire
Croatia
Djibouti
Dominican Republic
Ecuador
Egypt
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
IR - Iran
Iraq
Japan
Kazakhstan
Kenya
Kiribati
DPR - Korea
Republic of Korea
Kuwait
Kyrgyzstan
Lao PDR
Latvia
Lesotho
Liberia
Lithuania
TFYR of Macedonia
Madagascar
Malawi
Malaysia
Maldives
Mali
Mauritania
Mauritius
Mexico
Micronesia
Moldova-Rep
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Niue
N. Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Romania
Russian Federation
Rwanda
St. Vincent & The Grenadines
Sao Tome & Principe
Saudi Arabia
Senegal
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Spain
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Tanzania UR
Thailand
Timor-Leste
Togo
Tokelau
Tonga
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela
Viet Nam
Wallis & Futuna Islands
W. Bank & Gaza Strip
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Tuberculosis Control, WHO Report 2006, Countries with Tuberculosis incidence rates of > 20 cases per 100,000 population.

TB Screening & Risk Assessment Form

Student Health Center

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NAME ______________________ STUDENT ID NUMBER ______________________

ADDRESS ______________________

DATE OF BIRTH ____________ AGE ____________ PHONE ____________

TUBERCULOSIS (TB) RISK ASSESSMENT

(Required if "YES" was answered to any question on the TB Screening Questionnaire)

A. PATIENT SECTION

Recent close contact with someone with infectious TB disease	❑ Yes	❑ No
Foreign-born from (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America) *The significance of the travel exposure should be discussed with a health care provider and evaluated.	❑ Yes	❑ No
Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease	❑ Yes	❑ No
HIV/AIDS	❑ Yes	❑ No
Organ transplant recipient	❑ Yes	❑ No
Immunosuppressed (equivalent of > 15 mg/day of prednisone for >1 month or TNF-a antagonist)	❑ Yes	❑ No
History of illicit drug use	❑ Yes	❑ No
Resident, employee, or volunteer in a high-risk congregate setting (e.g. correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities).	❑ Yes	❑ No
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

B. HEALTHCARE PROVIDER SECTION: Proceed with testing as per below if "yes" to any question in section A.

(*Please Note: All testing must be within 6 months prior to arriving on campus – Discuss the significance of exposure and evaluate the patient*)

1. Does the student have signs or symptoms of active tuberculosis disease?

❑ **Yes** Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing (TST), chest x-ray, and sputum evaluation as indicated.

❑ **No** Proceed to #2 or #3. Completion of either #2 or #3 is required for **all** students with any "yes" answers in section A.

2. Tuberculin Skin Test (TST) TST result must 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.

See guidelines listed on the Instructions for Completing the Required Immunization Forms. **If positive, proceed to step 4.

Date Given: ____/____/____ Date Read: ____/____/_____ Result: ________ mm induration **Interpretation: Positive____ Negative____

3. Interferon Gamma Release Assay (IGRA):

****If positive, proceed to step 4.** Check the specific method: QFT-G QFT-GIT Other_____________

Date Obtained: ____/___/____ Result: Negative Positive Indeterminate

4. Chest X-Ray: Required if TST or IGRA is positive, or symptoms of active disease present. Attach a copy of the chest x-ray report to this document.
****If positive, proceed to step 5, if negative, proceed to step 6.**

Date of Chest X-ray: ____/____/______ Result: Normal Abnormal

5. Sputum Evaluation: Required if TST or IGRA is positive and if chest X-ray is positive, or symptoms of active disease present. Attach a copy of the sputum report to this document. After completion go to step 6.

Date Performed: _____/____/______ Result: Normal Abnormal

6. Diagnosis (check at least one)
****Required for all patients.**

_____ Active TB on Therapy
_____ Active TB Completed Therapy
_____ All tests Negative, (no disease)
_____ Other: ___________________
_____ Latent TB Infection on therapy
_____ Latent TB Infection declined or incomplete therapy
_____ Latent TB Infection completed therapy

REQUIRED SIGNATURE OF PHYSICIAN OR HEALTH FACILITY

NAME ______________________ PHONE NUMBER (________) ________ – ____________

ADDRESS ______________________

SIGNATURE (PHYSICIAN OR HEALTHCARE FACILITY, PLEASE PRINT & SIGN BEFORE SUBMITTING) ______________________ DATE ______ / ______ / ______