

**CERTIFICATE OF IMMUNIZATION (REQUIRED TO REGISTER FOR CLASS)**  
**(Ok to attach GRITS or other certified immunization record)**

REQUIRED IMMUNIZATIONS	REQUIREMENT (MM/DD/YYYY)	REQUIRED FOR:
<b>MMR</b> (Measles, Mumps, Rubella)  OR  <b>Measles (Rubeola)</b> AND <b>Mumps</b> AND <b>Rubella (German Measles)</b>	#1 ____/____/_____ #2 ____/____/_____  OR  #1 ____/____/_____ #2 ____/____/_____ OR Attached antibody titer (blood test) lab report #1 ____/____/_____ #2 ____/____/_____ OR Attached antibody titer (blood test) lab report #1 ____/____/_____ OR Attached antibody titer (blood test) lab report	<ul style="list-style-type: none"> <li>All foreign-born students regardless of year born</li> <li>US/Canadian students born in 1957 or later</li> <li>1<sup>st</sup> due at 12 months of age or older</li> <li>2<sup>nd</sup> dose administered no earlier than 28 days after 1<sup>st</sup> dose</li> <li>US/Canadian students born in 1957 or later</li> <li>If antibody titer does not indicate immunity, injection series required.</li> <li>1<sup>st</sup> due at 12 months of age or older</li> <li>2<sup>nd</sup> dose administered no earlier than 28 days after 1<sup>st</sup> dose</li> </ul>
<b>Varicella (Chicken Pox)</b>	#1 ____/____/_____ #2 ____/____/_____ OR Attached antibody titer (blood test) lab report OR Definitive diagnosis of varicella by healthcare provider. Provide statement from provider verifying previous infection.	<ul style="list-style-type: none"> <li><b>SELF/PARENTAL REPORTED HISTORY OF DISEASE NOT ACCEPTED</b></li> <li>All foreign-born students regardless of year born.</li> <li>US/Canadian born students born during or after 1980.</li> <li>1<sup>st</sup> due at 12 months of age or older</li> <li>2<sup>nd</sup> dose administered no earlier than 28 days after 1<sup>st</sup> dose</li> <li>If antibody titer does not indicate immunity, injection</li> </ul>
<b>Tetanus, Diphtheria, Pertussis (Tdap)</b>	Tdap ____/____/_____ <b>(REQUIRED)</b> <i>If unable at home country, obtain at UGA</i>	<ul style="list-style-type: none"> <li>One dose of Tdap for <i>all</i> students within past 10 years.</li> </ul>
<b>Hepatitis B</b>	#1 ____/____/_____ #2 ____/____/_____ #3 ____/____/_____  OR Attached antibody titer (blood test) lab	<ul style="list-style-type: none"> <li>All Students who will be 18 or younger on the first day of class.</li> <li>If antibody titer does not indicate immunity, injection series required.</li> <li>You <u>must</u> submit the antibody titer report on lab letterhead from a certified lab with definitive lab values in English.</li> </ul>
<b>Tuberculosis (TB)</b>	All students <b>MUST</b> complete the <b>Tuberculosis Screening Questionnaire</b> found on <a href="http://healthcenter.uga.edu/info/forms">healthcenter.uga.edu/info/forms</a>	<ul style="list-style-type: none"> <li>If the answer to any of the TB screening questions is YES, then must complete the TB Clinical Risk Assessment Part II of Form, including TST or IGRA by physician.</li> </ul>
<b>Meningococcal Vaccine ACWY(MCV4)</b>  (Strongly Recommended for all students <22)	#1 ____/____/_____ #2 ____/____/_____  Menactra or Menveo (Please circle one)	<ul style="list-style-type: none"> <li>All newly admitted UGA students living in Campus Housing, or</li> <li>Sorority or Fraternity Houses.</li> <li><b>NOTE:</b> A student may sign a statement of understanding in lieu of providing proof of immunization.</li> <li><b>Review meningitis disease information at:</b> <a href="http://healthcenter.uga.edu/healthtopics/meningitis">healthcenter.uga.edu/healthtopics/meningitis</a></li> </ul>
<b>Recommended Vaccines:</b> Meningitis B Vaccine: #1 ____/____/_____ #2 ____/____/_____ #3 ____/____/_____ (Bexsero/Trumenba) please circle Hepatitis A: #1 ____/____/_____ #2 ____/____/_____ HPV: #1 ____/____/_____ #2 ____/____/_____ #3 ____/____/_____ Influenza: ____/____/_____ COVID: #1 ____/____/_____ #2 ____/____/_____ #3 ____/____/_____ (Pfizer/Moderna/J&J) Please circle		

Request for Religious Exemption: I affirm that the immunizations required by the University System of Georgia, are in conflict with my religious beliefs I understand I am subject to exclusion in the event of an outbreak of disease which immunization is required. **(Attach Notarized Affidavit)**

Request for Permanent Medical Contraindication **(Attach Verification by HealthCare Provider)**

**REQUIRED SIGNATURE OF PHYSICIAN OR HEALTH FACILITY:**

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



NAME: \_\_\_\_\_

UGA ID#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## Part I: Tuberculosis (TB) Screening Questionnaire

Please answer the following questions:

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?  Yes  No

(If YES, please CIRCLE the country, below)

Afghanistan	Côte d'Ivoire	Kenya	Nicaragua	South Africa
Algeria	Democratic People's Republic of	Kiribati	Niger	South Sudan
Angola	Korea	Kuwait	Nigeria	Sri Lanka
Argentina	Democratic Republic of the	Kyrgyzstan	Niue	Sudan
Armenia	Congo	Lao People's Democratic	Pakistan	Suriname
Azerbaijan	Djibouti	Republic	Palau	Swaziland
Bahrain	Dominican Republic	Latvia	Panama	Taiwan
Bangladesh	Ecuador	Lesotho	Papua New Guinea	Tajikistan
Belarus	El Salvador	Liberia	Paraguay	Thailand
Belize	Equatorial Guinea	Libya	Peru	Timor-Leste
Benin	Eritrea	Lithuania	Philippines	Togo
Bhutan	Estonia	Madagascar	Poland	Trinidad and Tobago
Bolivia (Plurinational State of)	Ethiopia	Malawi	Portugal	Tunisia
Bosnia and Herzegovina	Fiji	Malaysia	Qatar	Turkey
Botswana	Gabon	Maldives	Republic of Korea	Turkmenistan
Brazil	Gambia	Mali	Republic of Moldova	Tuvalu
Brunei Darussalam	Georgia	Marshall Islands	Romania	Uganda
Bulgaria	Ghana	Mauritania	Russian Federation	Ukraine
Burkina Faso	Guatemala	Mauritius	Rwanda	United Republic of
Burundi	Guinea	Mexico	Saint Vincent and the	Tanzania
Cabo Verde	Guinea-Bissau	Micronesia	Grenadines	Uruguay
Cambodia	Guyana	(Federated States of)	Sao Tome and Principe	Uzbekistan
Cameroon	Haiti	Mongolia	Senegal	Vanuatu
Central African Republic	Honduras	Morocco	Serbia	Venezuela (Bolivarian
Chad	India	Mozambique	Seychelles	Republic of)
China	Indonesia	Myanmar	Sierra Leone	Viet Nam
Colombia	Iran (Islamic Republic of)	Namibia	Singapore	Yemen
Comoros	Iraq	Nauru	Solomon Islands	Zambia
Congo	Kazakhstan	Nepal	Somalia	Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2012. Countries with incidence rates of  $\geq 20$  cases per 100,000 population. For future updates, refer to <http://apps.who.int/ghodata>.

3. Have you had frequent or prolonged visits to one or more of the countries listed above with a high prevalence of TB disease? (If yes, CHECK the countries, above)  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 questions, University Health Center requires that you receive TB testing.  
If the answer to all of the above questions is NO, no further testing or further action is required.

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

Date: \_\_\_\_\_

(Or Signature of Parent if student is < 18 yrs. old)



**PART II. CLINICAL ASSESSMENT BY HEALTHCARE PROVIDER**

Clinicians should review and verify the information in Part I. Persons answering YES to any of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below)  Yes  No

History of BCG vaccination? (If yes, consider IGRA if possible.)  Yes  No

**1. TB Symptom Check<sup>1</sup>**

**Does the student have signs or symptoms of active pulmonary tuberculosis disease?**  Yes  No

\*If NO, proceed to 2 and 3. If YES, check below:

- Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- Coughing up blood (hemoptysis)
- Chest pain
- Loss of appetite
- Unexplained weight loss
- Night sweats
- Fever

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

**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:     /     /      
                  M      D      Y

Date Read:     /     /      
                  M      D      Y

Result: \_\_\_\_\_mm of induration      \*\*Interpretation: positive \_\_\_\_\_negative \_\_\_\_\_

Date Given:     /     /      
                  M      D      Y

Date Read:     /     /      
                  M      D      Y

Result: \_\_\_\_\_mm of induration      \*\*Interpretation: positive \_\_\_\_\_negative \_\_\_\_\_

**\*\*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 and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

**≥10 mm is positive:**

- Recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant\* amount of time
- Injection drug users
- Mycobacteriology laboratory personnel
- Residents, employees, or volunteers in high-risk congregate settings
- Persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

**≥15 mm is positive:**

- Persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.



University Health Center

Student Affairs

UNIVERSITY OF GEORGIA

UNIVERSITY HEALTH CENTER

University of Georgia

Athens, GA 30602-1755

Phone: 706-542-1162

Fax Nr: 706-542-4959

or 706-583-0777

NAME: \_\_\_\_\_

UGA ID#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: \_\_\_/\_\_\_/\_\_\_ (specify method) QFT-GIT T-Spot other\_\_\_
M D Y

Result: negative\_\_\_ positive\_\_\_ indeterminate\_\_\_ borderline\_\_(T-Spot only)

Date Obtained: \_\_\_/\_\_\_/\_\_\_ (specify method) QFT-GIT T-Spot other\_\_\_
M D Y

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\_\_\_
M D Y

PART III: MANAGEMENT OF POSITIVE TST OR IGRA

All students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- Infected with HIV
Recently infected with M. tuberculosis (within the past 2 years)
History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
Have had a gastrectomy or jejunioileal bypass
Weigh less than 90% of their ideal body weight
Cigarette smokers and persons who abuse drugs and/or alcohol

••Populations defined locally as having an increased incidence of disease due to M. tuberculosis, including medically underserved, low-income populations

\_\_\_\_ Student agrees to receive treatment

\_\_\_\_ Student declines treatment at this time

Required Signature of Healthcare Provider:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_