



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

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 _____



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 CHECK the country, below)

<input type="checkbox"/> Afghanistan	<input type="checkbox"/> Comoros	<input type="checkbox"/> Iraq	<input type="checkbox"/> Nigeria	<input type="checkbox"/> Tuvalu
<input type="checkbox"/> Algeria	<input type="checkbox"/> Congo	<input type="checkbox"/> Kazakhstan	<input type="checkbox"/> Niue	<input type="checkbox"/> Uganda
<input type="checkbox"/> Angola	<input type="checkbox"/> Côte d'Ivoire	<input type="checkbox"/> Kenya	<input type="checkbox"/> Northern Marina Islands	<input type="checkbox"/> Ukraine
<input type="checkbox"/> Anguilla	<input type="checkbox"/> Dem People's Republic of Korea	<input type="checkbox"/> Kiribati	<input type="checkbox"/> Pakistan	<input type="checkbox"/> Un. Rep. of Tanzania
<input type="checkbox"/> Argentina	<input type="checkbox"/> Dem Rep of the Congo	<input type="checkbox"/> Kuwait	<input type="checkbox"/> Palau	<input type="checkbox"/> Uruguay
<input type="checkbox"/> Armenia	<input type="checkbox"/> Djibouti	<input type="checkbox"/> Kyrgyzstan	<input type="checkbox"/> Panama	<input type="checkbox"/> Uzbekistan
<input type="checkbox"/> Azerbaijan	<input type="checkbox"/> Dominica	<input type="checkbox"/> Lao People's Dem Rep	<input type="checkbox"/> Papua New Guinea	<input type="checkbox"/> Vanuatu
<input type="checkbox"/> Bangladesh	<input type="checkbox"/> Dominican Republic	<input type="checkbox"/> Latvia	<input type="checkbox"/> Paraguay	<input type="checkbox"/> Venezuela (Bol. Rep.)
<input type="checkbox"/> Belarus	<input type="checkbox"/> Ecuador	<input type="checkbox"/> Lesotho	<input type="checkbox"/> Peru	<input type="checkbox"/> Viet Nam
<input type="checkbox"/> Belize	<input type="checkbox"/> El Salvador	<input type="checkbox"/> Liberia	<input type="checkbox"/> Philippines	<input type="checkbox"/> Yemen
<input type="checkbox"/> Benin	<input type="checkbox"/> Equatorial Guinea	<input type="checkbox"/> Libya	<input type="checkbox"/> Qatar	<input type="checkbox"/> Zambia
<input type="checkbox"/> Bhutan	<input type="checkbox"/> Eritrea	<input type="checkbox"/> Lithuania	<input type="checkbox"/> Republic of Korea	<input type="checkbox"/> Zimbabwe
<input type="checkbox"/> Bolivia (Plurinational State of)	<input type="checkbox"/> Eswatini	<input type="checkbox"/> Madagascar	<input type="checkbox"/> Republic of Moldova	
<input type="checkbox"/> Bosnia and Herzegovina	<input type="checkbox"/> Ethiopia	<input type="checkbox"/> Malawi	<input type="checkbox"/> Romania	
<input type="checkbox"/> Botswana	<input type="checkbox"/> Fiji	<input type="checkbox"/> Malaysia	<input type="checkbox"/> Russian Federation	
<input type="checkbox"/> Brazil	<input type="checkbox"/> French Polynesia	<input type="checkbox"/> Maldives	<input type="checkbox"/> Rwanda	
<input type="checkbox"/> Brunei Darussalam	<input type="checkbox"/> Gabon	<input type="checkbox"/> Mali	<input type="checkbox"/> Sao Tome and Principe	
<input type="checkbox"/> Bulgaria	<input type="checkbox"/> Gambia	<input type="checkbox"/> Malta	<input type="checkbox"/> Senegal	
<input type="checkbox"/> Burkina Faso	<input type="checkbox"/> Georgia	<input type="checkbox"/> Marshall Islands	<input type="checkbox"/> Sierra Leone	
<input type="checkbox"/> Burundi	<input type="checkbox"/> Ghana	<input type="checkbox"/> Mauritania	<input type="checkbox"/> Singapore	
<input type="checkbox"/> Cabo Verde	<input type="checkbox"/> Greenland	<input type="checkbox"/> Mexico	<input type="checkbox"/> Solomon Islands	
<input type="checkbox"/> Cambodia	<input type="checkbox"/> Guatemala	<input type="checkbox"/> Micronesia	<input type="checkbox"/> Somalia	
<input type="checkbox"/> Cameroon	<input type="checkbox"/> Guam	<input type="checkbox"/> Mongolia	<input type="checkbox"/> South Africa	
<input type="checkbox"/> Central African Republic	<input type="checkbox"/> Guinea	<input type="checkbox"/> Morocco	<input type="checkbox"/> South Sudan	
<input type="checkbox"/> Chad	<input type="checkbox"/> Guinea-Bissau	<input type="checkbox"/> Mozambique	<input type="checkbox"/> Sri Lanka	
<input type="checkbox"/> China	<input type="checkbox"/> Guyana	<input type="checkbox"/> Myanmar	<input type="checkbox"/> Sudan	
<input type="checkbox"/> China, Hong Kong SAR	<input type="checkbox"/> Haiti	<input type="checkbox"/> Namibia	<input type="checkbox"/> Suriname	
<input type="checkbox"/> China, Macao SAR	<input type="checkbox"/> Honduras	<input type="checkbox"/> Nauru	<input type="checkbox"/> Tajikistan	
<input type="checkbox"/> Colombia	<input type="checkbox"/> India	<input type="checkbox"/> Nepal	<input type="checkbox"/> Thailand	
	<input type="checkbox"/> Indonesia	<input type="checkbox"/> Nicaragua	<input type="checkbox"/> Timor-Leste	
		<input type="checkbox"/> Niger	<input type="checkbox"/> Togo	
			<input type="checkbox"/> Yokelau	
			<input type="checkbox"/> Tunisia	
			<input type="checkbox"/> Turkmenistan	

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

3. Have you had frequent (\geq twice/year) or prolonged ($>$ 1 month) 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
**If YES to questions 2 and/or 3: Date last traveled to high risk country _____ (month and year) **
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 (complete Part II).
If the answer to all of the above questions is NO, no further testing or further action is required.

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

Date: _____



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 Check¹

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 (PA and lateral), 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.



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. Note: a single PA view is indicated in the absence of symptoms)

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: _____