University Health Center
Student Affairs
UNIVERSITY OF GEORGIA

UNIVERSITY HEALTH CENTER
University of Georgia
Athens, GA 30602-1755
Phone: 706-542-1162
Fax : 888-218-9658

NAME: _____

UGA ID#: _____

Date of Birth: _____

CERTIFICATE OF IMMUNIZATION (REQUIRED PRIOR TO REGISTERING FOR CLASSES)

(Physician signature NOT required if attaching 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	• 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.	• **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)** ***If unable at home country, obtain at UGA***	• One dose of Tdap for ***all*** students within past 10 years.
Hepatitis B	#1____/____/_____ #2____/____/_____ #3____/____/_____ **OR** Attached antibody titer (blood test) lab	• 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 must 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	• 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.
RECOMMENDED VACCINES:		
Meningococcal Vaccine ACWY(MCV4) (Strongly Recommended for all students <22)	#1____/____/_____ #2____/____/_____ Menactra or Menveo (Please circle one)	• All newly admitted UGA students living in Campus Housing, 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

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-no older than 6 months signed by student)**

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

REQUIRED SIGNATURE OF PHYSICIAN OR HEALTH FACILITY:

Name_____Address_____Phone Number_____

Signature_____Date _____

Revised: 6/17; 5/19; 11/23;6/24, 5/25
Reviewed 5/25

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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)

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

Source: National Society of Tuberculosis Clinicians. Testing and Treatment of latent tuberculosis infection in the United States: clinical recommendations. Smyrna, GA: National Tuberculosis Controllers Association, February 2021.

3. Have you resided or traveled to 1 or more of the countries listed above for a cumulative period of 1 month or more? ❑ Yes ❑ No
(If yes, CHECK the countries, above)

**If YES to questions 2 and/or 3, list the month/year last traveled to this country _____

4. Have you been a resident, volunteer, 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 inactive TB infection or active TB disease - medically underserved, low-income, or using 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 _____ Date: _____
(Or Signature of Parent if student is < 18 yrs. old)

Form Reviewed: 3/17; 3/18; 7/21; 5/25
Form Revised: 3/2/2016; 5/22, 05/25

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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[1]

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.

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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 jejunoileal bypass
- ❑ Weigh less than 90% of their ideal body weight
- ❑ Cigarette smokers and persons who abuse drugs and/or alcohol

_____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: _____

Form Reviewed: 3/17; 3/18; 7/21,5/24, 5/25
Form Revised: 3/2/2016; 5/22; 5/25