



Certificate of Immunization

Due 30 days after semester begins

Monroe Park Campus
1300 West Broad Street, Suite 2200
Box 842022, Richmond, VA 23284-2022
PHONE (804) 827-8047 FAX (804) 828-1093
WEB www.health.students.vcu.edu/

All full-time students are required by the Code of Virginia (Section 23-7.5) to provide documentation of their immunizations by a licensed health professional. If you are unable to provide appropriate documentation, vaccines may be repeated. **A registration hold for the upcoming semester will be placed if all required immunizations are not up-to-date.**

Name _____
Last First MI
 Date of birth _____ Student V# _____ Mobile # () _____
 VCU Email _____ Address _____
 Were you born in the U.S.A.? Yes No If no, country of birth _____ Country of residence _____

Immunization		Dose 1 (MM/DD/YY)	Dose 2 (MM/DD/YY)	Dose 3 (MM/DD/YY)	Dose 4 (MM/DD/YY)
Required Immunizations					
† or ††	Hepatitis B / TWINRIX (circle one) OR HEPLISAV-B™				
†	Measles, Mumps, Rubella (MMR) After 1st birthday and ≥ 28 days apart				
††	Meningococcal Vaccine One dose required after 16th birthday				
	Polio Required for 18 and under OR from countries of high risk including Afghanistan, Nigeria and Pakistan.				
	Tdap or Td (circle one) Current dose within 10 years				
	Tuberculosis (TB) Screening All part and full time students are required to complete the tuberculosis screening form on page 3 OR complete and submit the electronic form available through the Web Portal.				
Recommended Immunizations					
	Diphtheria, Pertussis, Tetanus (DPT)	# doses rcv'd _____	last dose date _____		
	Hepatitis A				
	HPV: HPV4 ____ HPV9 ____				
	Meningococcal Group B MenB does not meet the Meningococcal Vaccine requirement				
	Varicella (Chicken Pox) After 1st birthday and ≥ 28 days apart OR date of disease (/ /)				
Alternatives † Attach lab result confirming serological immunity †† Sign Waiver : Complete the waiver on page 2 or submit the electronic form available through the Web Portal.					

Healthcare Provider or Health Department Signature _____ Date _____ Phone _____

Name

Date of Birth

Student V#



Waivers, Consent and Exemptions

Hepatitis B Vaccine Waiver

I have read and reviewed information on the risk associated with hepatitis B disease, availability and effectiveness of any vaccine against hepatitis B disease and I choose not to be vaccinated against hepatitis B disease.

Signature of Student or Parent/Legal Guardian

Date

Meningococcal Vaccine Waiver

I have read and reviewed information on the risk associated with meningococcal disease, availability and effectiveness of any vaccine against meningococcal disease and I choose not to be vaccinated against meningococcal disease.

Signature of Student or Parent/Legal Guardian

Date

Parental/Guardian consent for treatment of students age 17 years and younger

The law requires that parental permission be obtained in order to provide medical or surgical care to minors. This consent form should be signed by the parents so that medical care may be carried out promptly without unnecessary delays. I hereby authorize the physicians, clinicians, and staff nurses of VCU Student Health Services to examine, interview, test and, if necessary, treat my son/daughter as they deem advisable.

Signature of Student or Parent/Legal Guardian

Date

Medical Exemption

As specified in the Code of Virginia § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

DTP/DTaP/Tdap: [] ; DT/Td: [] ; OPV/IPV: [] ; Hib: [] ; Pneum: [] ; Measles: [] ; Rubella: [] ; Mumps: [] ; HBV: [] ; Varicella: []
Meningococcal: [] This contraindication is permanent: [] , or temporary [] and expected to preclude immunizations until:

Date (MM/DD/YY): _____

Signature of Medical Provider/Health Department Official

Date

Religious Exemption

Any student who objects on the grounds that administration of immunizing agents conflicts with his or her religious tenets or practices shall be exempt from the immunization requirements unless an emergency or epidemic of disease has been declared by the Board of Health. An affidavit of religious exemption must be submitted on a Certificate of Religious Exemption (Form CRE-1) found online by visiting health.students.vcu.edu, under the Immunizations tab, and then under the Forms & Documents page.

Name

Date of Birth

Student V#



Tuberculosis Screening Form

All part and full time students are required to complete this form OR complete and submit the electronic form available through the Web Portal.

The Centers for Disease Control and the U.S. Public Health Service recommend that tuberculosis testing be performed on ALL individuals who may be at increased risk of tuberculosis disease. For more information, visit <http://www.acha.org> or refer to the CDC's Core Curriculum on Tuberculosis available at <http://www.cdc.gov/nchstp/tb/pubs/corecurr/>.

- Have you had a prior positive TB test? Yes No
If yes, you must complete Page 4. Do not receive another TB skin test.
- Have you ever been a close contact with persons known or suspected to have active TB disease? Yes No
- Have you been a resident and/or employee in high risk settings such as long-term care facilities, homeless shelters or correctional facilities? Yes No
- Have you been a healthcare worker or volunteer serving high risk clients (such as the homeless, prison settings or hospitals)? Yes No
- Have you ever injected illegal drugs? Yes No
- Do you have signs or symptoms of active TB disease: unexplained fever, weight loss, loss of appetite, night sweats, persistent cough for more than 3 weeks, cough with production of bloody sputum? Yes No
- Do you have a clinical condition such as HIV, diabetes, cancer, kidney disease, silicosis, leukemia or lymphoma, chronic malabsorption syndromes, removal of part of your stomach or have been on prolonged corticosteroid or immunosuppressive therapy? Yes No
- Were you born in a country listed below and lived there for three (3) months or more?
If yes, what country? _____ Yes No
- Have you lived in or visited any country listed below for three (3) months or more?
If yes, what country? _____ Yes No

Afghanistan	Cambodia	Greenland	Madagascar	Panama	Syrian Arab Republic*
Algeria	Cameroon	Guam	Malawi	Papua New Guinea	Tajikistan
Angola	Central African Republic	Guatemala	Malaysia	Paraguay	Tanzania
Anguilla	Chad	Guinea	Maldives	Peru	Thailand
Argentina	China	Guinea-Bissau	Mali	Philippines	Timor-Leste
Armenia	Colombia	Guyana	Marshall Islands	Portugal	Togo
Azerbaijan	Comoros	Haiti	Mauritania	Qatar	Tokelau
Bahamas	Congo (Democratic Republic)	Honduras	Mauritius	Romania	Tunisia
Bangladesh	Republic)	India	Mexico	Russian Federation	Turkmenistan
Belarus	Cote d'Ivoire	Indonesia	Micronesia (Federal States)	Rwanda	Tuvalu
Belize	Djibouti	Iraq	Moldova (Republic of)	Sao Tome and Principe	Tanzania (United Republic)
Benin	Dominican Republic	Kazakhstan	Mongolia	Senegal	Uganda
Bhutan	Ecuador	Kenya	Morocco	Serbia	Ukraine
Bolivia	El Salvador	Kiribati	Mozambique	Sierra Leone	Uruguay
Bosnia and Herzegovina	Equatorial Guinea	Kuwait	Myanmar (Burma)	Singapore	Uzbekistan
Botswana	Eritrea	Kyrgyzstan	Nauru	Solomon Islands	Vanuatu
Brazil	Ethiopia	Korea (North and South)	Nepal	Somalia	Venezuela
Brunei Darussalam	Fiji	Lao	Nicaragua	South Africa	Viet Nam
Bulgaria	French Polynesia	Latvia	Niger	South Sudan	Yemen
Burkina Faso	Gabon	Lesotho	Nigeria	Sri Lanka	Zambia
Burundi	Gambia	Liberia	Northern Mariana Islands	Sudan	Zimbabwe
Burma (Myanmar)	Georgia	Lithuania	Pakistan	Suriname	
Cabo Verde	Ghana	Libya *	Palau	Swaziland	

___ I answered "YES" to 1 or more of the above questions. A TB test is required. Submit results of a TB test or IGRA done in the United States within the past year.
___ I answered "NO" to ALL of the above questions. No TB test is required.

Signature of Student or Parent/Legal Guardian _____ Date _____

Name _____ Date of Birth _____ Student V# _____



Tuberculosis Symptom Survey

Complete IF history of POSITIVE Tuberculin skin test or IGRA (T-Spot or QFT).

*Positive TB Test Date _____ Induration _____ ****OR Positive IGRA** Date _____

*Enclose copy of positive TB test documentation

**Enclose copy of report; IGRA = Quantiferon Gold or T-Spot

Last Chest X-Ray Date _____ Result _____ Enclose copy of latest chest x-ray report.

Have you taken medication for TB infection? Yes No

If Yes, Medication _____ Date began _____ Date completed _____

___INH _____Rifampin _____3HTP (12 week DOT)

Do you currently have any of the following symptoms?

- Cough lasting more than three weeks? Yes No
- Unexplained weight loss? Yes No
- Loss of appetite? Yes No
- Unexplained fatigue? Yes No
- Fever and night sweats? Yes No
- Blood tinged sputum production? Yes No

If "Yes" to any question, please explain further, including date of onset and any treatment.

I am aware that the six symptoms listed above are possible signs/symptoms of active tuberculosis disease that I should promptly report to my healthcare provider.

Signature of Student _____ Date _____

For Healthcare Provider Use:

I have reviewed the above information and agree with the student's information as indicated above.

LTBI treatment discussed ___ LTBI brochure offered ___

Healthcare Provider Signature _____ Date _____ Phone _____

Name

Date of Birth

Student V#



Waiver Information for Hepatitis B and Meningococcal Disease

Please read the following information on Hepatitis B and Meningococcal Disease before signing the waiver on the page 2 or the waiver available through the Web Portal.

Hepatitis B

Hepatitis B is a potentially fatal disease that attacks the liver. The virus can cause short-term (acute) illness that leads to loss of appetite, tiredness, diarrhea and vomiting, jaundice (yellow skin or eyes) and pain in muscles, joints and stomach. Many people have no symptoms with the illness. It can also cause long-term (chronic) illness that leads to liver damage, liver cancer and death.

According to the Centers for Disease Control, about 800,000 – 1.4 million people in the U.S. have chronic Hepatitis B infection. Each year approximately 40,000 people, mostly young adults, become infected with Hepatitis B virus. Young adults are more likely to contract Hepatitis B infection due to greater likelihood of high-risk behaviors such as multiple sexual partners.

Approximately 3,000 people die from chronic Hepatitis B infection annually. It is spread through contact with blood and body fluids of an infected person, such as having unprotected sex with an infected person or sharing needles when injecting illegal drugs. Unvaccinated health-science students are at risk of contracting Hepatitis B through an accidental occupational needle stick exposure.

There are several ways to prevent Hepatitis B infections including avoiding risky behavior, screening pregnant women and vaccination. Vaccine is the best prevention. The vaccine series typically consists of three injections given over a six month period, which are available through your private healthcare provider, health department or University Student Health Services.

Remember: Completion of the vaccine series is needed for protection against Hepatitis B disease.

Meningococcal Disease

Meningococcal disease is the leading cause of bacterial meningitis in children 2-18 years old in the U.S. Meningitis is an infection of the brain and spinal cord coverings. Meningococcal disease can also cause blood infections. According to the Centers for Disease Control, about 2,600 people get meningococcal disease each year in the U.S. Of these cases, 10-15% die and of those who live, another 10% may require limb amputation, develop kidney failure or brain damage, become deaf, suffer seizures or strokes.

College freshmen, particularly those who live in dormitories, have a slightly increased risk of getting meningococcal disease as illustrated by a case rate of 5.4/100,000 18-23 year olds as opposed to a case rate of 1.4/100,000 18-23 year olds in the general population.

Meningococcal vaccine is effective in preventing four types of meningococcal disease including two of the three most commonly occurring types in the U.S. The vaccine is 85-100% effective in preventing serotype A and C in older children and adults. It does not however protect against serotype B which causes one third of cases in patients 15-24 years. Therefore, in the event of an outbreak, even previously immunized individuals should contact their healthcare providers.

ACIP recommends routine vaccination of persons with meningococcal conjugate at age 11 or 12 years with a booster dose at age 16. Persons who receive their first meningococcal conjugate vaccine at or after 16 years do not need a booster dose. Routine vaccination of healthy persons 21 years or older who are not at increased risk of exposure to N. Meningitidis is not recommended.

The vaccine is available through your private healthcare provider, most local health departments and University Student Health Services.