GRADUATE STUDENT IMMUNIZATION FORM

PLEASE SUBMIT IMMUNIZATIONS ON THIS FORM. All graduate students are required to provide proof of immunization prior to enrollment in classes. If you have any questions, please direct them to University Health Service: (931) 598-1777. Please fax this completed form to (931) 598-1746. Hard copies may be mailed to University Health Service, University Wellness Center, SPO 1182, Sewanee, TN 37383-1000.

Student's Name: ________________________ DOB: _____________ Last 4 of SSN: _______ Phone #: ______________

Tuberculosis (TB) Skin Test – (Must be within the past 6 months) (N/A or Uncompleted is Not Acceptable)

1. Date placed ____/____/____ (M D YR) Read ____/____/____ (M D YR) Result (in millimeters) _____ mm Positive Negative
2. **If PPD is positive**, chest x-ray or Quantiferon testing is required.

   X-ray Date: ____________________ Result:____normal ____ abnormal

   Quantiferon Test Date: ____________________ Result: ____ negative ____ positive

****IF QUANTIFERON GOLD TEST OR CHEST X-RAY IS POSITIVE, ADDITIONAL TREATMENT PLAN MUST BE ATTACHED/SUBMITTED****

MMR (measles, mumps, rubella) – two doses are required or proof of immunity.

1. Dose 1 (at age 12 mos. or later) ____/____/____ (M D YR)
2. Dose 2 (at least 28 days after 1st dose) ____/____/____ (M D YR)
3. Mumps Antibody Titer: ____/____/____ (M D YR) Result: ____ (Reactive/Immunity) ____ (Non-Reactive)

   Rubella Antibody Titer: ____/____/____ (M D YR) Result: ____ (Reactive/Immunity) ____ (Non-Reactive)

   Rubeolla Antibody Titer: ____/____/____ (M D YR) Result: ____ (Reactive/Immunity) ____ (Non-Reactive)

Tetanus, diphtheria, pertussis – tetanus/diphtheria/pertussis (Tdap) is required within the last 10 years. Tetanus/diphtheria (Td) is not sufficient. Tdap booster recommended for ages 11 – 64 unless contraindicated. If Tdap will expire in the next 3 years please boost.

1. Tdap ____/____/____ (M D YR)

Hepatitis B – three doses of Hepatitis B are required.

1. Dose (1) ____/____/____ (M D YR) (2) ____/____/____ (M D YR) (3) ____/____/____ (M D YR)
2. Hepatitis B Surface Antibody Titer ____/____/____ (M D YR) Result: ____ (Reactive/Immunity) ____ (Non-Reactive)

Varicella – history of chicken pox disease, two doses of the vaccine or a positive antibody titer is required to meet the requirements.

1. Date of disease: ____/____/____ (M D YR)
2. Varicella Immunizations: (1) ____/____/____ (M D YR) (2) ____/____/____ (M D YR)
3. Varicella Antibody Titer: ____/____/____ (M D YR) Result: ____ (Reactive/Immunity) ____ (Non-Reactive)

*****STUDENTS AGE 22 AND UNDER ARE ALSO REQUIRED TO HAVE PROOF OF ONE MENINGOCOCCAL VACCINE AFTER AGE 16*****

Meningococcal (A, C, Y, W-135) – One dose required after the sixteenth birthday.

1. Menactra/Menveo ____/____/____ (M D YR) **(MUST BE AFTER AGE 16)**

Any Titers that report as Non-Reactive will require Patient to receive vaccinations, unless contraindicated.

Signature of Health Care Provider: ______________________________

Phone: (_______) ______________________ Fax: (_______) ______________________

Address: ______________________________

City: ______________________ State: ______________ Zip: ______________