LONGWOOD UNIVERSITY

Complete and return to: Longwood University ·Student Health & Wellness Center (SHWC)·201 High Street·Farmville, VA 23909·434.395.2102

# IMMUNIZATION RECORD

## PART I – TO BE COMPLETED BY STUDENT

Name _____
Last First Middle

Address _____
Street City State Zip

Date of Entry ____/_____ Date of Birth ____/____/_____ School ID# _____

Status: Full-time _____ Part-time _____ Graduate _____ Undergraduate _____

**____ Immunization Religious Exemption–** enclose notarized certificate from your state health department

*****PERMISSION TO TREAT***** (If you are under 18 when entering, your parent/guardian must sign below in order for you to be seen at the SHWC.)

I hereby authorize the clinicians of Longwood University Student Health and Wellness Center to examine, interview, test and treat the above named student as they may deem advisable and to disclose such information to other responsible University officials as necessary.

Signature _____ Date_____

## PART II – TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER (all information must be in English*)*

### MEDICAL EXEMPTION

__DPT __Td __OPV __Measles __Rubella __Mumps

As specified in Section 22.1-271.2, C(II) of the Code. I certify that administration of the vaccine(s) designated above would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because_____

This contraindication is ___permanent (or) ___temporary and expected to preclude immunization until __/__/____

### REQUIRED IMMUNIZATIONS (Record as Month/Day/Year)

**A. MMR (MEASLES, MUMPS, RUBELLA)** (Two doses **required** at least 28 days apart for students born after 1956)
Dose 1 given at age 12 months or later ..... #1 ____/____/_____
Dose 2 given at least 28 days after first dose. ..... #2 ____/____/_____
***Nursing – MMR Titers Required , can be option for others (attach copy of lab results)**..... ____/____/_____

**B. POLIO** (Primary series, doses at least 28 days apart with last dose after age 4 years. Three dose primary series is acceptable.)
OPV alone (oral Sabin three doses): #1 ____/____/_____ #2 ____/____/_____ #3 ____/____/_____
IPV/OPV sequential: IPV #1 ____/____/_____ IPV #2 ____/____/_____ OPV #3 ____/____/_____ OPV #4 ___/____/_____
IPV alone (injected Salk four doses): #1 ____/____/_____ #2 ____/____/_____ #3 ____/____/_____ #4 ____/____/_____

**C. TETANUS, DIPHTHERIA, PERTUSSIS**
Primary series completed? Yes ___ No ___
Date of last dose in series: ____/____/_____
Date of most recent booster dose: ____/____/_____ (must be less than 10 years ago)
Type of booster: Td _____ Tdap _____ (Tdap booster recommended for ages 11-64 unless contraindicated)

Name: _____ DOB: ____/_____/_____
Last First Middle M D Y

**D. HEPATITIS B** (Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or a positive hepatitis B surface antibody meets the requirement.) **Nursing and Athletic Training Students CANNOT Waive**

1. Immunization (hepatitis B)

   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____

   Adult formulation ____ Child formulation ____ Adult formulation ____ Child formulation ____ Adult formulation ____ Child formulation ____

2. Immunization (combined hepatitis A and B vaccine)

   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____

3. Hepatitis B surface antibody date ____/____/_____ Result: Reactive _____ Non-reactive _____

**OR:** I have read the information on the website (www.longwood.edu/health) and choose not to be vaccinated

_____
Signature of student or guardian if waived

**E. MENINGOCOCCAL QUADRIVALENT** One or 2 doses for all college students with last dose on or after 16th birthday– revaccinate every 5 years if increased risk continues. **Nursing Students CANNOT Waive**

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).

   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____

2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available).

   Date ____/____/_____

**OR:** I have read the information on the website (www.longwood.edu/health) and choose not to be vaccinated

_____
Signature of student or guardian if waived

**RECOMMENDED IMMUNIZATION (Record as Month/Day/Year)**

**F. VARICELLA** (Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement.)
History of Disease: Yes ___ No ___ or Birth in U.S. before 1980 Yes ___ No ___
Varicella antibody____/____ /_____ Result: Reactive _____ Non-reactive _____
***Nursing – Titer required (attach copy of lab results)**
Immunization
a. Dose #1 ____/____/_____
b. Dose #2 ____/____/_____ (given at least 12 wks. after first dose ages 1-12 yrs. and at least 4 weeks after first dose if age 13 yrs. or older)

**G. HUMAN PAPILLOMAVIRUS VACCINE (HPV2 or HPV4)** (3 doses of vaccine for all students 11-26 yrs. of age at 0, 1/2, and 6m intervals)
Immunization (indicate which preparation) Quadrivalent (HPV4) _____ or Bivalent (HPV2) _____
a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____

**H. INFLUENZA**
Date of last dose: ____/____/_____ Trivalent inactivated influenza vaccine (TIV) _____ Live attenuated influenza vaccine (LAIV) _____

**I. HEPATITIS A**

1. Immunization (hepatitis A)
   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____

2. Immunization (Combined hepatitis A and B vaccine)
   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____

**J. PNEUMOCOCCAL POLYSACCHARIDE VACCINE** (One dose for members of high-risk group)
Date ____/____/_____

Name: _____ DOB: ____/_____/_____
Last First Middle M D Y

**PART III – TO BE COMPLETED BY STUDENT AND HEALTH CARE PROVIDER**

## Tuberculosis (TB) Screening/Risk Assessment for All Entering Students

**Student**, please answer the following questions:

1. Have you ever had a positive TB skin test? ☐ Yes ☐ No
2. Have you ever had close contact with anyone who was sick with TB? ☐ Yes ☐ No
3. Were you born in a country NOT listed below and arrived in the U.S. within the past 5 years? ☐Yes ☐ No
   If YES what country? _____
4. Have you ever traveled* to/in one or more country NOT listed below? ☐ Yes ☐ No
   If YES what country(ies)? _____
5. Have you ever been vaccinated with BCG? ☐ Yes ☐ No
6. Are you an Athletic Training or Nursing major? ☐ Yes (PPD/IGRA and/or negative CXR required annually) ☐ No

Albania, Andorra, Antigua and Barbuda, Australia, Austria, Bahamas, Barbados, Belgium, British Virgin Islands, Canada, Chile, Costa Rica, Cuba, Cyprus, Czech Republic, Denmark, Dominica, Egypt, Fiji, Finland, France, Germany, Greece, Grenada, Hungary, Iceland, Iran (Islamic Republic of), Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Luxembourg, Malta, Mexico, Nauru, Netherlands, New Zealand, Norway, Oman, Puerto Rico, Saint Kitts and Nevis, Saint Lucia, Samoa, Saudi Arabia, Slovakia, Slovenia, Spain, Sweden, Switzerland, United Arab Emirates, United Kingdom, United States of America, West Bank and Gaza Strip

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**Health Care Provider:** Please review above and complete remainder of tuberculosis risk assessment (to be completed within six months of the start of classes). Individuals with any of the following are candidates for either tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

**Risk Factor**

1. Recent close contact with someone with infectious TB disease ☐ Yes ☐ No
2. Foreign-born from (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America) ☐ Yes ☐ No
3. Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease ☐ Yes ☐ No
4. HIV/AIDS ☐ Yes ☐ No
5. Organ transplant recipient ☐ Yes ☐ No
6. Immunosuppressed (equivalent of > 15 mg/day of prednisone for >1 month or TNF-α antagonist) ☐ Yes ☐ No
7. History of high risk illicit drug use ☐ Yes ☐ No
8. Resident, employee, student or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities) ☐ Yes ☐ No
9. Medical condition associated with increased risk of progressing to TB disease if infected [e.g., diabetes mellitus, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal for the given population)] ☐ Yes ☐ No

** The significance of the travel exposure should be discussed with a health care provider and evaluated.*

*1.* Is student at high risk for exposure to TB? ☐ Yes ☐ No *If no then TB testing not required proceed to page 4 for signature*

2. Does the student have signs or symptoms of active tuberculosis disease? ☐ Yes ☐ No
   *If YES, proceed with additional evaluation to exclude active tuberculosis disease including TST/IGRA, chest x-ray, and sputum evaluation as indicated. If NO and any previous answers YES proceed with appropriate TB test.*

Name: _____ DOB: ____/_____/_____
Last First Middle M D Y

3. 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: ____/____/____ Date Read: ____/____/____
Result: _____ mm of induration **Interpretation: positive____ negative____

(If 2 step test needed complete 2nd test 1-3 weeks from first test)
Date Given: ____/____/____ Date Read: ____/____/____
Result: _____ mm of induration **Interpretation: positive____ negative____

4. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/___/___ (specify method) QFT-G QFT-GIT T-Spot other_____
Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

Date Obtained: ____/___/___ (specify method) QFT-G QFT-GIT T-Spot other_____
Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

5. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: ____/____/____ Result: normal____ abnormal_____

6. TB prevention medication taken: ☐ Yes ☐ No If yes, dates taken: ____/____/_____ -____/____/_____

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****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
- Immunosuppressed persons: taking > 15 mg/d of prednisone for >1 month; taking a TNF-α antagonist
- Persons with HIV/AIDS

**>10 mm is positive:**
- Persons born in a high prevalence country or who resided in one for a significant* amount of time
- History of illicit drug use
- Mycobacteriology laboratory personnel
- History of resident, worker, student or volunteer in high-risk congregate settings
- Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes

*The significance of the travel exposure should be discussed with a health care provider and evaluated.

**>15 mm is positive:**
- Persons with no known risk factors for TB disease.

ADDITIONAL COMMENTS

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_____
_____
_____

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**HEALTH CARE PROVIDER**

**SIGNATURE** _____ **ADDRESS** _____

**DATE** _____ **PHONE** _____

_____ _____

**Longwood Reviewer** **Date**