VCU University Student Health Services
Student Affairs

VCU Health Sciences Certificate of Immunization

Due 30 days before program begins

MCV Campus
1000 E. Marshall St., Room 305
Richmond, VA 23298-0201
PHONE (804) 828-9220 FAX (804) 828-3181
WEB www.health.students.vcu.edu/

The Office of the Senior Vice President for Health Sciences is responsible for crafting, interpreting, and revising this policy.

Name _____
Last First MI

Date of birth _____ Student V# _____ Mobile # ( ) _____

VCU Email _____ Address _____

Circle Accepted Program Allied Health Dentistry Medical Pharmacy Nursing

Immunization	Dose 1 (MM/DD/YY)	Dose 2 (MM/DD/YY)	Dose 3 (MM/DD/YY)	Dose 4 (MM/DD/YY)	Dose 5 (MM/DD/YY)	Dose 6 (MM/DD/YY)
Required Immunizations						
Hepatitis B / TWINRIX *(circle one) 3 doses*						
OR HEPLISAV-B™ *2 doses*						
AND Serological confirmation of immunity *Attach copy of Hepatitis B Surface Antibody QUANTITATIVE lab report.*					Result _____ mIU/ml	
Influenza: *Due annually by December 1*						
Measles, Mumps, Rubella (MMR) *2 doses after 1st birthday and ≥ 28 days apart* ***OR serological confirmation of immunity with copy of quantitative lab report***						
Meningococcal vaccine *One dose required after 16th birthday*						
OR Meningococcal Vaccine Waiver I have 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						
Polio: *Primary series IPV or OPV.* *Required for students 18 and younger OR from high risk countries including Afghanistan, Nigeria and Pakistan. Documentation may be required for clinical rotation sites.*						
Tdap or Td *(circle one)* *Documentation of a current Tdap or Td. If Td, include documentation of Tdap since 2005. (Some clinical rotations may require a current Tdap.)*						
Tuberculosis (TB) Screening: *Complete Tuberculosis Screening/Testing information on the next page.*						
Varicella (Chicken Pox) *2 doses after 1st birthday and ≥ 28 days apart* ***OR date of disease*** *(/ /) AND serological confirmation of immunity with copy of* ***QUANTITATIVE LAB REPORT*** *(Titer is not required if 2 doses of vaccine spaced ≥ 28 days apart).*						
Recommended Immunizations						
DPT/DTaP *(primary series)*						
Hepatitis A						
HPV Vaccine						

I have reviewed the Immunization and Tuberculosis information.

Healthcare Provider (Print Name) _____ Healthcare Provider Signature _____ Date _____ Phone _____

For up-to-date vaccine information and recommendations for healthcare workers, visit http://www.cdc.gov/vaccines/adults/rec-vac/hcw.html
This form (and any attachments) will be used for data entry purposes only and will be destroyed upon completion of data entry. Please retain a copy for your records.

VCU is an EEO/AA Institution | USHS1819-10 | Revised 8/2018

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Tuberculosis Testing/Screening

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Name _____
Last First MI

Date of birth _____ Student V# _____

REQUIRED: Newly enrolled students **MUST** undergo a two-step Tuberculin skin test (TST) **OR** have 1 Interferon Gamma Release Assay Test (IGRA). All testing and X-Rays must be done in the USA. Annual tuberculosis testing thereafter per program requirements.

A. Two-Step TST
Tests must be done at least 7 days apart but no more than 30 days between first and second TST placement or series must be repeated.

Test 1: Date Placed _____ Date Read _____ Result (mm) _____ ___ positive ___ negative

Test 2: Date Placed _____ Date Read _____ Result (mm) _____ ___ positive ___ negative

B. IGRA (QFT Gold or T-Spot)

Date performed _____ Result Date _____ ___ positive ___ negative **Attach copy of lab report**
Indeterminate or borderline results are not acceptable. Repeat test or administer Two-Step TST.

C. History of a prior Positive TST or IGRA (QFT Gold or T-Spot)

Date of Positive _____ Result (mm) _____ or attach IGRA report

D. TB Symptom Survey (Check all that apply)

___ None
___ Cough > 3 weeks with or without sputum production
___ Coughing up blood
___ Unexplained fever
___ Poor appetite
___ Unexplained weight loss
___ Night sweats
___ Fatigue

If "Yes" to any question, please explain further.

_____

_____

E. Chest X-Ray
Required **ONLY** if POSITIVE TST or POSITIVE IGRA. Chest X-ray must be **after** positive TST or IGRA and within **6** months of program start date. A negative chest x-ray is not a substitute for tuberculosis testing. **Attach copy of x-ray report.**

F. Treatment for TB disease or Latent TB Infection
Dates of treatment regimen: _____ to _____ **Attach documentation**
___ INH ___ Rifampin ___ 3HTP (12 week DOT) ___ LTBI treatment offered, pt. declined

I have reviewed the Immunization and Tuberculosis information.

Healthcare Provider (Print Name) Healthcare Provider Signature Date Phone

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