University Student Health Services

Monroe Park Campus
1300 West Broad Street, Suite 2200
Box 842022
Richmond, VA 23284-2022
PH: 804-827-8047 Fax: 804-828-1093
https://health.students.vcu.edu/

Health Sciences Campus
1000 E. Marshall St., Room 305
Richmond, VA 23298-0201
PH: 804-828-9220 Fax: 804-828-3181
https://health.students.vcu.edu/

Certificate of Immunization P.1

All full-time students are required by the Code of Virginia (Section 23.1-800) 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 Middle Initial

Date of Birth:_____ **Student V#:** _____ **Mobile #: ( )**_____

VCU Email:_____ **VCU 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** (3 dose series or TWINRIX (circle one) OR 2 dose HEPLISAV-B ™)				X
				X	X
†	**Measles, Mumps, Rubella (MMR)** After 1st birthday and ≥ 28 days apart			X	X
††	**Meningococcal Vaccine** One dose required after 16th birthday		X	X	X
	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		X	X	X
	Tuberculosis (TB) Screening/Testing (All part and full time students are required to complete the tuberculosis screening form on page 4 OR complete and submit the electronic form available through the Web Portal.)				
	OPTIONAL IMMUNIZATIONS				
	Diphtheria, Pertussis, Tetanus (DPT)	# doses rec:_____		last dose date:_____	
	Hepatitis A			X	X
	HPV: HPV4____ HPV9____				X
	Meningococcal Group B (MenB does not meet the Meningococcal Vaccine requirement)				X
	Varicella (Chicken Pox) After 1st birthday and ≥ 28 days apart OR date of disease (Day/Month/Year) (/ /)			X	X
	COVID 19: Updated Annually **Circle One: Pfizer Moderna**		X	X	X
	Influenza: Updated Annually		X	X	X

Alternatives† Attach lab result confirming serological immunity†† Sign Waiver : Complete the waiver on page 3 or submit the electronic form available through the Web Portal.

_____ _____ _____
Healthcare Provider or Health Department Signature **Date** **Phone**

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Certificate of Immunization P.2

Name:_____ **Date of Birth**:_____ **Student V#**_____

	Additional Vaccination Requirements Generally Required by Clinical Training Sites		
Please verify requirements with your clinical site. For up-to-date vaccine information and recommendations for healthcare workers, visit https://www.cdc.gov/vaccines/adults/rec-vac/index.html#other. Click on Life Events, Job, and Travel and then Healthcare workers.			
	COVID 19: Updated Annually **Circle One: Pfizer Moderna**	MM/DD/YY	
	Influenza: Update annually	MM/DD/YY	
†	**Varicella (Chicken Pox)** Two doses after 1st birthday and ≥ 28 days apart OR Serological confirmation of Immunity with a copy quantitative lab report. (Titer is not required if doses of vaccine spaced 28 days apart)	Dose 1 MM/DD/YY	Dose 2 MM/DD/YY
†	**Hepatitis B Titer** Serological confirmation of immunity with copy of quantitative lab report		
	Alternatives† Attach lab result confirming serological immunity		
	Tuberculosis(TB)Testing Undergo two-step Tuberculin skin test (TST) OR have 1 Interferon Gamma Release Assay Test (IGRA)		

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)

*Please complete page 5 TB symptom survey.
*Chest X-Ray must be after positive TST or IGRA and within 6 months of program start date.

Healthcare Provider or Health Department Signature **Date** **Phone**

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Waivers, Consent, and Exemptions

Name:_____ **Date of Birth**:_____ **Student V#**_____

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:[ ]; Influenza [ ]
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.

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Virginia Tuberculosis Risk Assessment

Name:_____ **Date of Birth**:_____ **Student V#**_____

First screen for TB Symptoms (check all that apply):

___None ___Cough (3 weeks or more)___Hemoptysis ___Fever ___Weight Loss ___Poor Appetite ___Night Sweats___Fatigue

If present, evaluate for active TB disease. If none, complete the risk factor portion below.

____Have you had a prior positive TB test (PPD or IGRA)? Yes____No____
*If yes, please complete the TB symptom survey form on page 5 and sign below.

Use this tool to identify asymptomatic **individuals 6 years and older** for latent TB infection (LTBI) testing.

- Re-testing should only be done in persons who previously tested negative and have new risk factors since the last assessment.
- A negative Tuberculin Skin Test (TST) or Interferon Gamma Release Array (IGRA) does not rule out active TB disease.
- Once your information is reviewed by Student Health, you may be contacted for further follow-up information.

Check appropriate risk factors below.

TB infection testing is recommended from the **past year** (must be completed in the US) if any of the risks below are checked.

If TB infection result is positive and active TB disease is ruled out, TB infection treatment is recommended.

____**Birth, travel, or residence in a country with an elevated TB rate ≥ 3 months**

- Includes countries other than the United States (US) , Canada, Australia, New Zealand, or Western and North European countries.
- IGRA is preferred over TST for non-US-born persons ≥ 2 years old.
- Clinicians may make individual decisions based on the information supplied during the evaluation. Individuals who have traveled to TB-endemic countries for the purpose of medical or health tourism < 3 months may be considered for further screening based on the risk estimated during the evaluation.

____**Medical conditions increasing risk for progression to TB disease**

Radiographic evidence of prior healed TB, low body weight (10% below ideal), silicosis, diabetes mellitus, chronic renal failure or on hemodialysis, gastrectomy, jejunoileal bypass, solid organ transplant, head and neck cancer.

____**Immunosuppression, current or planned**

HIV infection, injection drug use, organ transplant recipient, treatment with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥ 15 mg/day for ≥ month) or other immunosuppressive medication

____**Close contact** to someone with infectious TB disease at any time

____**None**, no TB testing indicated at this time.

_____

Signature of Student or Parent/Legal Guardian **Date**

_____

Provider Signature (if indicated) **Date**

Once your form is reviewed, you may be contacted for more information if indicated.

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Tuberculosis Symptom Survey

Name:_____ **Date of Birth**:_____ **Student V#**_____

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 a TB infection? Yes_____ No_____

If Yes, Medication_____ Date began:_____ Date Completed:_____

____INH ____Rifampin ____3HP (12 week DOT) ____3HR

Are you interested in discussing latent TB infection treatment with a clinician? Yes_____No____

Do you currently have any of the following symptoms (circle yes or no)?

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

If "Yes" to any questions, 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**