



IMMUNIZATION RECORD

Non CHS Graduate Students – Due one month prior to arrival/classes

Name: _____ SU ID: _____
Last First MI

Email address: _____ Date of Birth: ____/____/____

Phone number: (____)____-_____

Enrolling: Fall Jan Term Spring Summer of Year 20____ Program of Study: _____

Living in Campus Housing? Yes [] No []

TUBERCULOSIS SCREENING (student must answer BOTH screening questions)

1. Does the student have signs or symptoms of active tuberculosis disease? (symptoms include: persistent , coughing up blood, fever, fatigue, unexplained weight loss, etc.)

Yes [] No [] **If No, proceed to 2. If yes, proceed to #3** for additional evaluation to exclude active tuberculosis disease.

2. Is the student a member of a high risk group or is the student entering a health profession? Yes [] No [] **If No, stop. If yes, proceed below.**

-High risk students include those who have arrived within the past 5 years from any country EXCEPT: Western Europe, Canada, Australia or New Zealand. Additional high-risk categories include those with HIV infection or other immunosuppressive disorders, h/o IV drug use, or those who have resided in, or worked in high-risk congregate settings such as prisons, shelters, hospitals, nursing homes, etc.

-Also includes students currently working in a healthcare setting or entering into the clinical portion of a health profession field of study; does not include pre-requisite courses

3. If the student answers 'yes' to either of the questions above, please proceed with the Tuberculosis screening:

a. PPD Skin Test (Mantoux): Must be within 6 months of entrance date.

Date Given: _____ Date Read: _____ Results: (mm induration) _____ **If positive, report to Health Department for further evaluation (chest x-ray and IGRA)**
month/day/year month/day/year

b. Healthcare workers/students require a **one-time** 2-step PPD Skin Test (must be at least 1 but no greater than 3 weeks after the first skin test)

Date Given: _____ Date Read: _____ Results: (mm induration) _____ **If positive, report to Health Department for further evaluation (chest x-ray and IGRA)**
month/day/year month/day/year

OR

c. IGRA (Quantiferon gold or T-spot) accepted in lieu of TB Skin test within 6 months of entrance **for students with history of positive TB Skin test.**

- Must provide copy of lab report, chest x-ray report of negative findings, and the Samford TB questionnaire. **Result** _____ **Date** _____

OR

d. Chest x-ray (required if student has history of latent or active TB disease*) -Date of Chest x-ray (must be within 6 months of entrance): _____

-Results: Normal [] Abnormal []

-Must attach documentation of treatment, chest x-ray report, and TB questionnaire.

VACCINATIONS REQUIRED OF ALL STUDENTS:

M.M.R. (Measles, Mumps and Rubella)

Born before 1957, no MMR immunization required

Combined Vaccines (Two doses; at least one month apart)

M.M.R (Measles,Mumps,Rubella)	#1 ____/____/____ month/ day/ year	#2 ____/____/____ month/day/yea r
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OR

Individually Administered Vaccines

Measles	#1 ____/____/____ month/day/year	#2 ____/____/____ month/day/year
Mumps	#1 ____/____/____ month/day/year	
Rubella	#1 ____/____/____ month/day/year	

OR

Laboratory Evidence of Immunity (all 3 required) in lieu of vaccines

*must submit copy of lab report

*if not immune, please complete the vaccination series

Measles	#1 ____/____/____ month/day/year	Result: Immune or Non-Immune
Mumps	#1 ____/____/____ month/day/year	Result: Immune or Non-Immune
Rubella	#1 ____/____/____ month/day/year	Result: Immune or Non-Immune



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Tdap (TETANUS-DIPHTHERIA-ACELLULAR PERTUSSIS)

At least one dose required within the last 10 years	____/____/____ month/ day/ year
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VACCINATIONS REQUIRED OF STUDENTS LIVING ON CAMPUS:

VARICELLA (Chickenpox) ALSO REQUIRED FOR STUDENTS ENROLLED IN THE COLLEGE OF HEALTH SCIENCES

History of Disease	____/____/____ Month Day Year (Minimum Month/Year as date accepted) please provide laboratory evidence of immunity if date not available)	OR	Immunizations (Two doses required)	#1 ____/____/____ Month Day Year	#2 ____/____/____ Month Day Year	OR	Laboratory Evidence of Immunity* ____/____/____ Month Day Year RESULT: <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune
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*must provide copy of lab report
 *if not immune, please complete the vaccination series

MENINGOCOCCAL (quadrivalent - A,C,Y, W-135) (must have one dose since 16th birthday)

Immunization	____/____/____ Month Day Year
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RECOMMENDED VACCINATIONS:

HEPATITIS B - REQUIRED FOR STUDENTS ENROLLED IN THE COLLEGE OF HEALTH SCIENCES

Immunizations	#1 ____/____/____ Month Day Year	#2 (at least one month after dose #1) ____/____/____ Month Day Year	#3 (at least six months after dose #1 OR four months after dose #2) ____/____/____ Month Day Year	OR	Hepatitis B Surface Antibody (*must provide copy of lab report)	Laboratory Evidence of Immunity* ____/____/____ Month Day Year	RESULT: <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune
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Health Provider or Nurse Signature: _____ Date: _____ within 6 months of entrance

Print Name: _____ Phone: (____) _____ - _____

Address: _____

**RETURN COMPLETED FORM TO:
 SAMFORD UNIVERSITY**

GRADUATE STUDENTS – DELIVER TO PROGRAM ADMISSIONS COORDINATOR