IMMUNIZATION RECORD

Required of all students – Due two weeks 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**
month/day/year month/day/year **for further evaluation (chest x-ray and IGRA)**

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**
month/day/year month/day/year **for further evaluation (chest x-ray and IGRA)**

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/year

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

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: [ ] Immune [ ] Non-Immune

*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

RECOMMENDED VACCINATIONS:

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

Immunizations

#1	#2 (at least one month after dose #1)	#3 (at least six months after dose #1 OR four months after dose #2)
/ / Month Day Year	/ / Month Day Year	/ / Month Day Year

OR

Laboratory Evidence of Immunity*

Hepatitis B Surface Antibody *(*must provide copy of lab report)*	/ / Month Day Year	RESULT: [ ] Immune [ ] Non-Immune

THIS SECTION TO BE FILLED OUT BY HEALTH CARE PROVIDER ONLY (within 6 months of entrance)

Student Health Information

□**Please list any potential communicable illnesses**: _____

_____

MD/PA/NP Signature: _____ Date:_____ within 6 months of entrance

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

Address: _____

RETURN COMPLETED FORM TO:
ADMISSIONS- SAMFORD UNIVERSITY
(UPLOAD ONLINE VIA APPLICATION STATUS PAGE)

GRADUATE STUDENTS – EMAIL TO PROGRAM ADMISSIONS COORDINATOR