Samford University
College of Health Sciences

IMMUNIZATION RECORD

Required of all CHS students – Due one month prior to arrival/classes

Name:_____ **SU ID:**__ __ __ __ __ __ __ __ __
Last *First* *MI*

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

Phone number: (____)_____-_____

Enrolling: ☐Fall ☐ Spring ☐ Summer of **Year** 20___ **Program of Study:** _____

Living in Campus Housing? Yes [ ] No [ ]

Immunization history must be completed and signed by a health care provider
OR
Upload original immunization records directly to ESS at www.Es2.com

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

Tdap (TETANUS-DIPHTHERIA-ACELLULAR PERTUSSIS)

At least one dose required within the last 10 years	_____/_____/_____ month/ day/ year

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

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VACCINATIONS REQUIRED

INFLUENZA (required between September and August)

Immunization	/ / Month Day Year

HEPATITIS B

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

VACCINATIONS REQUIRED OF ALL STUDENTS LIVING ON CAMPUS:

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

Immunization	/ / Month Day Year

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: _____

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Patient _____
LAST *FIRST* *MI*

TUBERCULOSIS SCREENING:

The College of Health Sciences (CHS) at Samford University requires a two-step Tuberculosis (TB) screening two-step PPD skin test, a chest x-ray, or an IGRA blood test for all CHS students. If you have received BCG vaccine, an IGRA test is preferred. If you have a history of a positive TST (PPD) ≥10mm or IGRA please supply information regarding any evaluation and/or treatment below. **You only need to complete one section.** Guidelines are based upon the recommendation of the CDC and the American College Health Association.

The two-step TB test must be administered between one (1) and three (3) weeks apart.

Section A		**Date Placed**	**Date Read**	**Reading**
Negative Skin Test, Blood Test, or Chest X-ray	TST #1	_____/____/_____	_____/____/_____	_____ mm
	TST #2	_____/____/_____	_____/____/_____	_____ mm
	IGRA Blood Test □ T-spot □ Quantiferon Gold		□ Attach copy	
	Chest X-ray		□ Attach copy	
OR				
Section B		**Date Placed**	**Date Read**	**Reading**
History of Latent Tuberculosis, Positive Skin Test, or Positive Blood Test	Positive TST	_____/____/_____	_____/____/_____	_____ mm
	Positive IGRA Blood Test	**Date** _____/____/_____	**Type Test** □ T-spot □ Quantiferon Gold	□ Attach copy
	Chest X-ray	_____/____/_____	□ Attach copy	
	Prophylactic medications for latent TB taken?		□ Yes □ No	
	Total duration of prophylaxis?		_____ months	
	Date of last annual TB symptom questionnaire (if applicable)		_____/____/_____	
OR				
Section C				
History of Active Tuberculosis	Date of Diagnosis		_____/____/_____	□ Attach copy
	Date Treatment Completed		_____/____/_____	□ Attach copy
	Date of last annual TB symptom questionnaire (if applicable)		_____/____/_____	□ Attach copy
	Date of last Chest X-ray		_____/____/_____	□ Attach copy

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

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

Address: _____

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