FURMAN

Immunization Record

Name _____ DOB ____ / ____ / _____ SS # _____ - _____ - _____
(Last) (First) (Middle)

Furman University ***REQUIRES*** the following immunizations upon the recommendation of the American College Health Association, South Carolina Department of Health and U.S. Public Health.

This Section Must Be Completed and Signed By Your Health Care Provider.

All Dates Must Include Month, Day, and Year

A. M.M.R. (Measles, Mumps, Rubella) -*Two doses:* ***Required***
Dose #1 given at age 12-15 months or later..... #1 ____ / ____ / _____

Dose #2, given at least 28 days after first dose..... #2 ____ / ____ / _____

B. TDaP Booster (Tetanus, diphtheria, and pertussis): ***Required***
To replace single dose of Td for booster immunization at least 2-5 years since last dose of Td, depending on age of patient..... Date ____ /____ / ____

C. Hepatitis B (Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or positive Hep B surface antibody): ***Required***

a. Vaccine Dates .....Dose #1 ____ / ____ / _____ Dose #2 ____ / ____ / _____ Dose #3 ____ / ____ / _____
b. Hepatitis B surface antibody .....Test Date ____ /____ /_____ Results Reactive __ Non-Reactive __ *(Attach a copy of report).*

D. Varicella (A history of chickenpox, a positive Varicella antibody, or two doses of vaccine to meet national standard requirement): ***Required***

a. History of chickenpox: Yes __ No __ History Date (Month/Year) ____ / ____
b. Immunization: Dose #1 ____ / ____ / ____; Dose #2 ____ / ____ / ____
c. Varicella antibody..... Test Date ____ / ____ / ____ Results Reactive __ Non-Reactive __ *(Attach a copy of report)*

E. Meningococcal Tetravalent ******Highly Recommended******
Tetravalent Conjugate (MCV-4)..... Date ____ / ____ / ____
- If received before age 16, a booster is recommended.....Date ____/ ____/ _____

Meningitis B (Serogroup Meningococcal B)
- May be indicated for high-risk individuals, which can include college students living in dorms
  1. MenB-RC (Bexsero).....Dose #1 _____/_____/_____ Dose #2_____/_____/_____ **, OR**
  2. MenB-FHbp (Trumenba).....Dose #1_____/_____/_____ Dose #2_____/_____/_____
     Dose #3_____/_____/_____

F. Tetanus-Diphtheria (Primary series with DTaP, DTP or DT, and booster with TD or Tdap in the last 10 years meets requirements): ***Recommended***
1. Primary series of four doses with DTaP, DTP, or DT
   #1 ____ / ____ / _____ #2____ / ____ / _____#3 ____ / ____ / _____ #4 ____ / ____ / _____ #5 ____ / ____ / _____

G. Hepatitis A: ***Recommended***
1. Immunization (hepatitis A) a. Dose #1 ___/ ___/ ___ b. Dose #2 ___/___/___

H. Quadrivalent Human Papillomavirus Vaccine (HPV): ***Recommended***

(Three doses of vaccine for students 11-26 years of age years of age at 0, 2 and 6-month intervals.)
Dose #1 ___/ ___/ ___ Dose #2 ___/___/___ Dose # 3 ___/___/___

I. Influenza: ***Recommended*** (Trivalent inactivated influenza vaccine, TIV, or live attenuated influenza vaccine, LAIV)

Date of last Dose ____ / ____ / ____ TIV ___ LAIV ___

J. Pneumococcal Polysaccharide Vaccine: ***Recommended***
(One dose for members of high-risk groups)..... Date ____ / ____ / _____

K. Polio (OPV, IPV or IPV/OPV) [Circle one] Primary series in childhood meets requirement: ***Recommended***

#1 ____ / ____ / _____ #2____ / ____ / _____#3 ____ / ____ / _____ #4 ____ / ____ / _____ #5 ____ / ____ / _____

L. Covid Vaccine: ***Recommended***

Pfizer	Dose #1 ___ /___ /___	Dose #2 ___ /___ /___
Moderna	Dose #1 ___ /___ /___	Dose #2 ___ /___ /___
Johnson & Johnson	___ /___ /___	
COVID Booster	___ /___ /___	

Tuberculosis (TB) Screening

Please answer *ALL* of the following questions:

Have you ever had a positive TB skin test? Yes _____ No _____

Have you ever had close contact with anyone who was sick with TB? Yes _____ No _____

Where you born in one of the countries listed below and arrived in the U.S. within the past 5 years? Yes_____ No _____

(If yes, please circle the country below)

Have you ever traveled to/in one or more of the countries listed below? Yes _____ No _____

(If yes, please check the country/ies)

Have you ever been vaccinated with BCG? Yes _____ No _____

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Burma (Myanmar)
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
Colombia
Congo (Democratic Republic)
Congo (Republic of)
Cote d'Ivoire
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran* (Islamic Republic of)
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Korea (North and South)
Laos
Latvia
Lesotho
Liberia
Lithuania
Libya*
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mexico*
Micronesia (Federal States)
Moldova (Republic of)
Mongolia
Morocco
Mozambique
Myanmar (Burma)
Nauru
Nepal
Nicaragua
Niger
Nigeria
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Serbia
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic*
Tajikistan
Thailand
Timor-Leste Tongo
Tunisia
Turkmenistan
Tuvalu
Tanzania (United Republic)
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela
Vietnam
Wallis and Futuna Islands
Yemen
Zambia
Zimbabwe

If the answer is YES to any of the above questions, Furman University requires that a healthcare provider complete a 1-step PPD test. See form on next page.

***Locally identified high burden countries not meeting WHO definition of ≥20/100,000**

Tuberculosis (TB) Risk Assessment *continued*

Please answer ALL of the following questions

1. Does the student have signs or symptoms of active tuberculosis disease? Yes _____ No _____
If No, proceed to 2 or 3. If yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)
(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0".
The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ____/____/____ Date Read: ____/____/____

Result: _____ mm of induration **Interpretation: positive____ negative____

3. Chest x-ray: (Required if TST or IGRA is positive)
Date of chest x-ray: ____/____/____ Result: normal____ abnormal____

Interpretation Guidelines

>5 mm is positive:
- *Recent close contacts of an individual with infectious TB*
- *Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease*
- *Organ transplant recipients*
- *Immunosuppressed persons: taking > 15 mg/d of prednisone for > 1month; taking a TNF-α antagonist*
- *Persons with HIV/AIDS*

>10 mm is positive:
- *Persons born in a high prevalence country or who resided in one for a significant* amount of time*
- *History of illicit drug use*
- *Mycrobacteriology laboratory personnel*
- *History of resident, worker or volunteer in high-risk congregate settings*
- *Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes*

>15 mm is positive:
- *Persons with no known risk factors for TB disease*

Healthcare Provider (required only for PPD test or other vital medical information)

Name _____ Address _____

Signature _____ Phone ( ) _____