

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 DatesDose #1 ____ / ____ / ____ Dose #2 ____ / ____ / ____ Dose #3 ____ / ____ / ____

b. Hepatitis B surface antibodyTest 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. Covid Vaccine: Required

Pfizer Dose #1 ____ / ____ / ____ Dose #2 ____ / ____ / ____

Moderna Dose #1 ____ / ____ / ____ Dose #2 ____ / ____ / ____

Johnson & Johnson ____ / ____ / ____

F. 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 ____ / ____ / ____

G. 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 ____ / ____ / ____

H. Hepatitis A: Recommended

1. Immunization (hepatitis A) a. Dose #1 ____ / ____ / ____ b. Dose #2 ____ / ____ / ____

I. Quadrivalent Human Papillomavirus Vaccine (HPV): Recommended

(Three doses of vaccine for female college students 11-26 years of age years of age at 0, 2 and 6-month intervals.)

Dose #1 ____ / ____ / ____ Dose #2 ____ / ____ / ____ Dose # 3 ____ / ____ / ____

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

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

K. Pneumococcal Polysaccharide Vaccine: Recommended

(One dose for members of high-risk groups)..... Date ____ / ____ / ____

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

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

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	Guatemala	Palau
Algeria	Guinea	Panama
Angola	Guinea-Bissau	Papua New Guinea
Argentina	Guyana	Paraguay
Armenia	Haiti	Peru
Azerbaijan	Honduras	Philippines
Bangladesh	India	Portugal
Belarus	Indonesia	Qatar
Belize	Iran* (Islamic Republic of)	Romania
Benin	Iraq	Russian Federation
Bhutan	Kazakhstan	Rwanda
Bolivia	Kenya	Sao Tome and Principe
Bosnia and Herzegovina	Kiribati	Senegal
Botswana	Kuwait	Serbia
Brazil	Kyrgyzstan	Sierra Leone
Brunei Darussalam	Korea (North and South)	Singapore
Bulgaria	Laos	Solomon Islands
Burkina Faso	Latvia	Somalia
Burundi	Lesotho	South Africa
Burma (Myanmar)	Liberia	South Sudan
Cabo Verde	Lithuania	Sri Lanka
Cambodia	Libya*	Sudan
Cameroon	Madagascar	Suriname
Central African Republic	Malawi	Swaziland
Chad	Malaysia	Syrian Arab Republic*
China	Maldives	Tajikistan
Colombia	Mali	Thailand
Congo (Democratic Republic)	Marshall Islands	Timor-Leste Tongo
Congo (Republic of)	Mauritania	Tunisia
Cote d'Ivoire	Mexico*	Turkmenistan
Djibouti	Micronesia (Federal States)	Tuvalu
Dominican Republic	Moldova (Republic of)	Tanzania (United Republic)
Ecuador	Mongolia	Uganda
El Salvador	Morocco	Ukraine
Equatorial Guinea	Mozambique	Uruguay
Eritrea	Myanmar (Burma)	Uzbekistan
Ethiopia	Nauru	Vanuatu
Fiji	Nepal	Venezuela
French Polynesia	Nicaragua	Vietnam
Gabon	Niger	Wallis and Futuna Islands
Gambia	Nigeria	Yemen
Georgia	Northern Mariana Islands	Zambia
Guam	Pakistan	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 $\geq 20/100,000$

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
- Mycobacteriology 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 () _____