



Immunization Record

Students born after 12/31/1956 must provide proof of compliance with immunization requirements of the Commonwealth of Virginia and George Mason University. Students who fail to comply with these requirements will not be able to enroll for courses the following semester. Enter all information in English formats. If you are unable to provide appropriate documentation, vaccines may be repeated.

Records are due to Student Health Services by MARCH 1st for the SPRING Semester and OCTOBER 1st for the FALL Semester. Late records may be assessed a LATE FEE.

PART I. TO BE COMPLETED BY THE STUDENT * — PLEASE PRINT *United States address required for all International Students

Form with fields for Last Name, First Name, Date of Birth, G#, Address, City, State, Zip, and Phone.

PART II. TUBERCULOSIS SCREENING

Tuberculosis (TB) screening is required of all students. Please answer the following questions:

- Have you ever had a POSITIVE Tuberculosis Skin Test (TST)?
Were you born in Asia, Africa, Central or South America or Eastern Europe, and arrived in the US within the last 5 years?
Have you travelled to/in Asia, Africa, Central or South America or Eastern Europe, for three consecutive months or more within the last 5 years?
Are you a Health Care Worker, Nursing Student or is a TB test required by your academic program?
Have you had close contact with anyone who is/was sick with Tuberculosis?

If the answer is YES to any of the above question, George Mason University requires that a Health Care Provider complete a Tuberculosis Risk Assessment.

If the answer to all of the above questions is NO, no further testing or action is required.

Office Use Only: [Empty box]

PART III. REQUIRED IMMUNIZATIONS DATE ADMINISTERED (MM/DD/YY)

Table with 3 columns: Immunization Name, Date Administered, and Notes. Rows include Tetanus-Diphtheria, Measles/Mumps/Rubella (MMR), Hepatitis B (HBV), and Meningococcal.

If this document is not signed by a Health Care Provider, please attach a copy of the supporting documentation.

PART VI: ADDITIONAL REQUIREMENTS FOR HEALTH SCIENCE MAJORS

DATE ADMINISTERED (MM/DD/YY)

Varicella (chicken pox): Two doses at least one month apart for adults (1) ___/___/___ (2) ___/___/___ OR copy of titer indicating positive immunity

Tuberculosis Skin Test (TST): Date Placed: ___/___/___ Date Read: ___/___/___ Results: _____ mm
 Positive Negative

CHEST X-RAY: required if Tuberculin Skin test is positive Result: Normal Abnormal Date if Chest X-ray: ___/___/___
 INH Initiated ___/___/___ x _____ months

PART IV: RECOMMENDED VACCINATIONS **DATE ADMINISTERED (MM/DD/YY)**

Varicella (chicken pox): Two doses 1 month apart for adults with no history of the disease (1) ___/___/___ (2) ___/___/___

Gardasil (HPV): for females ≤ 26 yr old (1) ___/___/___ (2) ___/___/___ (3) ___/___/___

Hepatitis A (If Twinrix, see required immunizations above) (1) ___/___/___ (2) ___/___/___ Twinrix noted above

Other (Specify): _____ (1) ___/___/___ (2) ___/___/___ (3) ___/___/___

PART V. OTHER VACCINATIONS RECEIVED **DATE ADMINISTERED (MM/DD/YY)**

Polio IPV or OPV Has received _____ doses, last dose given ___/___/___

EXEMPTIONS:

Letter from HCP required _____ Religious Exemption: Form CRE-1 required _____

REQUIRED ONLY IF STUDENT IS UNDER 18 YEARS OF AGE AT THE TIME OF ENROLLMENT

Parental permission or the consent of a legal guardian must be obtained to provide medical or surgical care to minors. To avoid delays in treatment in the event of illness or accident, please obtain the signature of a parent/legal guardian if you are under 18 years of age..
 I hereby authorize the staff of George Mason University Student Health Services to assess, test, and, if necessary, treat my son or daughter as they may deem advisable.

 Signature of Parent or Guardian _____
 Date

 Printed Name of Parent or Guardian _____
 Relationship

Signature Required of Health Care Provider:
 Transcribed records Gave Vaccine to student
 Printed Name and Title: _____
 Name of Practice or Clinic: _____
 Address: _____
 Phone Number: _____

Signature: _____ Date _____