GEORGE MASON UNIVERSITY | Student Health Services

Immunization Record Form

shs.gmu.edu/immunizations

INSTRUCTIONS

Visit the website for office hours and more information.

- **Completed immunization forms are due by August 1st for Fall/Summer and January 5th for Spring enrollment.**
- **All records must be in English. Student and Healthcare Provider must fill out the Immunization Form in ink ("see attached" is not acceptable documentation). All dates must be entered onto form (check marks not acceptable).**
- Student name and G# must be on each page of submitted form and records.
- ALL students must complete Parts 1 and 3. Part 2 must be completed by parent/guardian if student is under 18 years of age.
- ALL students born after 12/31/1956 must provide proof of immunizations listed in Part 5.
- Part 4 (if required), Part 5, Part 6 and Part 7 of this form must be completed and signed by a healthcare provider. Part 4 refers to whether a TB test is required based on answers from Part 3.
- Records that are late or incomplete after appropriate deadlines will be assessed a late fee and a hold will be placed on the student's Patriot Web account. The hold will prevent class registration for the following semester.
- Transcription service is available for a fee at Student Health Services. See SHS website for description of Transcription Service. If a student is unable to provide appropriate documentation, immunizations and/or titers are also available for a fee. All support doucments must include two patient identifiers (patient name and date of birth along with clinic/provider information).
- Students will receive communication from the Immunization Office regarding compliance/non-compliance through a secure message to their Mason email. The notification will state that they have a secure message and should log into the patient portal to read it. These messages may go to a spam/junk email; check or edit mail options.
- **Student Health Services reserves the right to request supporting documentation of your immunization records, and request titers and/or vaccinations at your expense.**

SUBMIT FORM AND RECORDS (DO NOT FAX OR EMAIL)

Upload to Patient Portal (preferred method): https://gmu.medicatconnect.com

OR Mail records: George Mason University Student Health Services 4400 University Drive, MS 2D3, Fairfax, VA 22030

Students can check record status in the portal. Print services (on campus) offers scanning service for students.

PART 1. PERSONAL INFORMATION - TO BE COMPLETED BY ALL STUDENTS, PRINT LEGIBLY

Legal Last Name _____ **Legal First Name** _____ **Student G#** _____

U.S. Address _____

City _____ **State** Select state **Zip Code** _____

Date of Birth _____ **Home Phone** _____ **Cell Phone** _____

PART 2. MINOR CONSENT - ONLY IF STUDENT IS UNDER 18 YEARS AT 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 at the time of enrollment.

I hereby authorize the staff of George Mason University Student Health Services to assess, test, administer vaccines, and if necessary, treat my minor or dependent as deemed advisable.

Parent/Guardian Signature: _____ Date: _____

Printed Name of Parent/Guardian: _____ Relationship: _____

ALLOWABLE EXEMPTIONS: DO NOT APPLY TO TUBERCULOSIS SCREENING/TESTING

Medical: Mason Medical Exemption Form completed and signed by healthcare provider. Upload to the patient portal.

Religious Exemption: Original, Signed and notarized Commonwealth of Virginia form CRE-1 required. Upload to the Patient Portal.

Student Name: _____ Date of Birth: _____ G # _____

PART 3 . TUBERCULOSIS SCREENING - Baseline Individual TB Risk Assessment

Please answer the following questions to assist SHS in performing a TB Risk Assessment.

Select Yes or No

Have you ever tested positive for TB? *If yes go to Part 4. You will need to supply documentation of a positive test (historical or current), and documentation of a chest x-ray dated within 3 months of classes starting.* *If no, go to next question.*	☐ Yes ☐ No
Have you ever lived in any country other than the United States for more than a month at time?" Where were you born/lived? _____	☐ Yes ☐ No
Have you ever traveled to any country other than the United States for more than one month? Where have you traveled? _____	☐ Yes ☐ No
Do you have an immuno-suppresive disease? *Persons who are receiving immune-suppressive medications such as corticosteroid or drug therapy following organ transplantation and persons with immune-suppressive conditions such as HIV, diabetes mellitus, chronic renal failure, leukemia, or cancer.*	☐ Yes ☐ No
Have you ever received a Bacillus Calmette-Guerin (BCG) vaccine?	☐ Yes ☐ No
Have you had close contact with anyone who is or was sick with tuberculosis (TB)?	☐ Yes ☐ No
Have you resided in, volunteered or worked in a prison, nursing home, hospital, or homeless shelter?	☐ Yes ☐ No
Do you have any symptoms of active tuberculosis, such as: Cough > 3 weeks, night sweats, fever unexplained weight loss and/or fatigue?	☐ Yes ☐ No

Provider to proceed to page 3, part 4 for further tuberculosis evaluation.

Student Name:_____ Date of Birth: _____ G # _____

PART 4. TUBERCULOSIS TEST - TO BE COMPLETED AND SIGNED BY A HEALTHCARE PROVIDER AFTER THE PROVIDER REVIEWS THE TB RISK ASSESSMENT. All lab reports and chest x-ray reports that are required must be submitted with this form. All forms must be in English and include Patient's full name and date of birth.

Did the Student answer yes to any questions in Part 3, or was born outside of the US?

_____**If Yes**, They MUST undergo TB testing with either a Tuberculin Skin Test (TST) or TB blood test (Interferon Gamma Release Assay/IGRA), If there is no history of a previous positive test, obtain a test and document in Section A, then continue to the following sections.

Document any previous positive test immediately below and submit all pertinent records, including a chest x-ray within 90 days of the first day of classes. (Skip to Section B)

Date of Past Positive TB Test: _____ Result: _____mm (if TST). Please submit lab report if test was IGRA.

_____**If No**, please sign the bottom of page 3 then proceed to Page 4 (part 5).

Students who have had BCG are required to have a TB test. It is recommended they do a TB Immunoassay Blood Test (IGRA) Copy of Lab report must accompany the form.

Section A: TB Test - (Skin test OR Blood test) Copy of test/report must accompany the form (test must be dated less than 3 months from the first day of classes)

Blood Test: IGRA - submit lab report

OR

Skin Test: Date Placed:_____ Results: _____mm Date Read: _____

Please record actual mm of induration, transverse diameter; if no induration, write "0" Must be 48-72 hours from placement

Section B: Chest X-Ray - If patient has a documented history of positive TB test, a chest x-ray report must be submitted with this form. Chest x-ray must be dated less than 3 months from the first day of classes. Only students who have successfully completed treatment for latent TB infection may be considered for an exemption of this requirement. Those students must submit evidence of successful LTBI treatment and be evaluated by an SHS clinician prior to a possible exemption being granted.

Section C: Treatment for TB or LTBI - Documentation of treatment must be submitted with form

Date treatment started: _____ Date treatment completed: _____

Name of medication:_____

Name of Practice:_____ Contact Phone Number:_____

Healthcare Provider Signature: _____ Date:_____

Student Name: _____ Date of Birth: _____ G # _____

PART 5: REQUIRED IMMUNIZATIONS - TO BE COMPLETED BY A HEALTHCARE PROVIDER WHO MUST ALSO COMPLETE AND SIGN PART 7. SHS will not accept "see attached" all dates must be written in. All titer reports must be submitted with the Immunization Record form for proper documentation. All supporting documents must include patients full name and date of birth. All documents must be in English or translated by a certified medical translator. SHS follows the CDC guidelines.

TETANUS-DIPHTHERIA Must show proof of Tetanus/diphtheria/pertussis vaccine after age 11. If vaccine has expired (more than 10 years), also show proof of tetanus vaccine (TD or Tdap) within the last 10 years.

Tdap within past 10 years AND after age 11 _____ { OR } **Tdap date after age 11** _____ **AND** **TD less than 10 years** _____

MEASLES, MUMPS, RUBELLA (MMR) 2 doses of MMR required at least 1 month apart. First dose must be given on or after one year of age; and after 1971 for combined MMR vaccine or after 1967 for individual doses

(1) _____ **(2)** _____ **MMR Combined**

OR **TWO (2) DOSES OF EACH OF THE FOLLOWING VACCINES:**

Measles (Rubeola) **(1)** _____ **(2)** _____

Mumps **(1)** _____ **(2)** _____

Rubella (German Measles) **(1)** _____ **(2)** _____

☐ **OR** Copy of titer lab work indicating **positive** immunity must be submitted with form

HEPATITIS B (HBV) Must receive a complete series at appropriately spaced intervals to be considered immune

(1) _____ **(2)** _____ **(3)** _____

Check One

(1)	(2)	(3)
☐ Hepatitis B	☐ Hepatitis B	☐ Hepatitis B
☐ Twinrix	☐ Twinrix	☐ Twinrix
☐ Heplisav	☐ Heplisav	

OR ☐ Copy of titer lab work indicating **positive** immunity must be submitted with form **OR** ☐ signed waiver on part 8 of this form

MENINGOCCOCAL QUADRIVALENT (A, C, Y, W-135) _____ At least one does between the ages of 16 and 21

OR ☐ signed waiver on part 8 of this form **OR** ☐ over 21 years of age (not required to show proof of vaccination)

PART 6. RECOMMENDED IMMUNIZATIONS - TO BE COMPLETED BY A HEALTHCARE PROVIDER. SHS will not accept "see attached" all dates must be written in. All titer reports must be submitted with the Immunization Record form for proper documentation. All supporting documents must include patients full name and date of birth. All documents must be in English or translated by a certified medical translator. SHS follows the CDC guidelines.

VARICELLA (chicken pox) **(1)** _____ **(2)** _____ or copy of titer report submitted with form

HUMAN PAPILLOMAVIRUS (HPV)

(1)	(2)	(3)
_____	_____	_____
☐ HPV 4	☐ HPV 4	☐ HPV 4
☐ HPV 9	☐ HPV 9	☐ HPV 9

HEPATITIS A (If Twinrix, see Part 5, Hepatitis B) **(1)** _____ **(2)** _____ or titer report submitted with form

MENINGOCOCCAL TYPE B (not MCV ACYW) (1) _____ **(2)** _____ **(3)_if needed**_____ ☐ Bexsero ☐ Trumenba

Strongly recommended if living in a dorm or dorm like facility - will not document if type is unknown

PART 7. HEALTHCARE PROVIDER (RN, NP, MD, DO, PA) INFORMATION AND SIGNATURE ALL INFORMATION REQUIRED, including provider credentials

☐ Transcribed Records ☐ Administered Vaccine (s)

Printed Name and Credentials/Title: _____

Name of Practice: _____

Clinic Address: _____ Phone Number: _____

Healthcare Provider Signature: _____ Date: _____

Student Name: _____ Date of Birth: _____ G # _____

PART 8: WAIVERS FOR HEPATITIS B AND MENINGOCOCCAL

WAIVER OF IMMUNIZATION AGAINST HEPATITIS B DISEASE
only if no previous record of vaccination

Hepatitis B is a serious liver disease caused by the hepatitis B virus (HBV). HBV infection can affect people of all ages and lead to liver disease. The virus is found in the blood and body fluids of infected people it is most often spread among adults through sexual contact or by sharing needles and other drug paraphernalia with an infected person. HBV can also be spread in households of HBV-infected persons or by passage of the virus from an HBV-infected mother to her infant during birth. Hepatitis B can be a silent disease, often infecting many people without making them feel sick. Unfortunately, 30 percent of those infected with HBV are not aware that they are carriers and can infect others. Hepatitis B symptoms might include loss of appetite, fatigue, stomachache, nausea and vomiting, yellowing of the whites of the eyes (jaundice), and/or joint pain. Vaccination can help prevent people from contracting hepatitis B. The HBV vaccine is 96 percent effective following a series of three shots over a six-month period. The most common side effect of the vaccine is soreness at the injection site. Vaccine recipients cannot get the disease from the vaccine.

*I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at anytime. I have received and reviewed the information regarding hepatitis B and the availability and effectiveness of the hepatitis B vaccine. I have chosen **not** to be vaccinated (or I am unable to provide current vaccination records) against hepatitis B.*

_____	_____	_____	_____
Student Signature	Date	If student is a minor, Parent/Guardian Signature required also	Date

WAIVER OF IMMUNIZATION AGAINST MENINGOCOCCAL DISEASE
only if no previous record of vaccination

Meningitis is an inflammation of the linings of the brain and spinal cord. It is caused by bacteria called *Neisseria meningitidis.* The bacteria are transmitted through air-borne droplets of respiratory secretions and by direct contact with infected persons. Although bacterial meningitis occurs rarely and sporadically throughout the year, increased outbreaks occur among college students, especially those who live in residence halls. Early symptoms of meningococcal disease include fever, severe headache, stiff neck, rashes, and exhaustion. If not treated early, meningitis can lead to severe and permanent disabilities or even death. A vaccine is available that protects against four strains of the bacteria that cause meningitis in the United States: types A, C, Y, and W-135. These types account for nearly two-thirds of meningitis cases among college students. The vaccine is safe, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to two days. The vaccine is 85 to 100 percent effective.

*I have received and reviewed the information regarding meningococcal disease and the availability and effectiveness of the meningococcal vaccine. If in the future I want to be vaccinated with meningococcal vaccine, I can receive the vaccination at anytime. I have chosen **not** to be vaccinated against meningococcal disease.*

_____	_____	_____	_____
Student Signature	Date	If student is a minor, Parent/Guardian Signature required also	Date